
# Country Operational Plan

# (COP/ROP) 2020

# Strategic Direction Summary

**Date:** 07-24-2020

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# 1.0 Goal Statement

PEPFAR Kenya's goal is to support Kenya's effort to achieve and sustain HIV epidemic control through a *tiered county public health response that ensures high community-level viral suppression, reduces HIV infections across all populations, and accelerates national and county government ownership.*

Efficiency, county leadership, client-centered service delivery, root cause analysis, and strong partnership will govern COP20 implementation. Resources will be prioritized based on need, guided by the most updated HIV estimates. The 40 counties receiving direct support will be categorized into 3 clusters to guide the case finding approach: high (≥80%), medium (70-79%), and low ( <70%) antiretroviral (ART) coverage. Specific interventions for ART scale-up will be driven by granular site-level data on burden, coverage, unmet need, yield, linkage, and net ART growth. Analysis will also include a review of incidence data to guide scale up for efficient and effective HIV prevention interventions including pre-exposure prophylaxis (PrEP), Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS), voluntary medical male circumcision (VMMC), and key populations (KP) programs.

Working in collaboration with national and county governments, PEPFAR Kenya will support implementation of key enabling policies for case finding, treatment, prevention, orphans and vulnerable children (OVC), and health systems support. At the program level, PEPFAR Kenya will build on successful ART scale up and viral load (VL) coverage and suppression, as well as index testing for case identification to institute a road map toward epidemic control and self-reliance. Persistent programmatic gaps such as low DREAMS program completion rates, suboptimal retention and linkage to ART, attrition from care for PBFW and high mother-to-child transmission (MTCT) of HIV, and poor performance in some counties will be addressed. A public health approach to case identification, utilizing recency testing to define and respond to geographic "hot spots," will be adopted.

PEPFAR Kenya continues to report improved VL suppression at 92% as of FY20 Q1. However, there are still challenges with poor suppression among children, adolescents, and young adults. COP20 will focus on improving suppression among these populations while maintaining the successful strategies used in adults. PEPFAR will forge strong partnerships with county governments so efforts can be focused on bringing back those lost to follow-up and improving retention of clients on lifelong treatment, including a focus on young and healthy individuals who are at a higher risk of being lost to follow-up. Through root cause analysis, the program will employ both proactive and reactive measures to ensure minimal missed appointments and rapid re-engagement into treatment for those falling out, including appropriate redeployment of human resources for health (HRH) and use of technology.

Preliminary results from the DREAMS Recency Study found younger adolescent girls and young women (AGYW) (aged 15-19 years) and non-DREAMS participants had a higher

proportion of recent infections among new HIV diagnoses compared to older AGYW (aged 20-24 years) and DREAMS participants. The study also demonstrated the feasibility of conducting Asanté™ HIV-1 Rapid Recency® Assay. In COP20, national HIV recency surveillance will be rolled out to all counties in phases by order of highest contributors to HTS_POS and counties exhibiting a surge in new infections. Recency data will be incorporated into data use and public health action planning at national, regional, and county levels to target prevention and testing interventions in geographic "hot spots."

In order to sustain the gains made in the HIV epidemic response, PEPFAR Kenya will build on systems investments at county level through collaboration between the County Health Management Teams (CHMTs) and designated county lead and systems support implementing partners (IPs). Through this collaboration, county transition plans will be developed to both enhance ownership and journey toward self-reliance. There will be engagement at various levels to ensure recognition and regularization of community-level cadres and formalization of task shifting and sharing standards.

To further support the national and county governments in their journey toward self-reliance, PEPFAR Kenya will continue to engage all stakeholders to support efforts toward epidemic control. During planning for COP20 the stakeholders provided invaluable input into the conceptualization, development, and implementation of the COP20 process as well as during the quarterly PEPFAR Oversight and Accountability Response Team (POART) and key technical working group (TWG) meetings. Alongside exemplary commitments by the Government of Kenya (GOK), Global Fund (GF), United Nations family (UN), private sector, and civil society (CSOs) and faith-based organizations (FBOs), we will continue to work closely with all stakeholders during the implementation of COP20 to ensure that the complementary efficiencies and the priorities set forth in this Strategic Direction Summary (SDS) lead to epidemic control.

# 2.0 Epidemic, Response, and Program Context

**2.1 Summary statistics, disease burden and country profile**

Based on the 2019 population census, Kenya's population is 47.6 million, 50.5% of whom are female and 39% (18.5 million) of whom are children aged <15 years (KPHC, 2019). Adult HIV prevalence is 4.9%, with substantial geographic variation ranging from 0.1% in Garissa County to 19.6% in Homabay county (KENPHIA, 2018). By September 2020, there will be an estimated 1.5 million people living with HIV (PLHIV), of whom 100,000 are children aged <15 years (Spectrum/Naomi 2020 estimates). Females are disproportionately affected, with a prevalence more than double that of men, at 6.6% versus 3.1% respectively (KENPHIA, 2018). In 2019, it was estimated that there were 40,825 new HIV infections, representing an adult HIV incidence of 0.14% (KENPHIA, 2018) compared to 0.5% in 2012 (KAIS, 2012). AGYW aged 15-24 years contributed to 26% of all new HIV-infections. HIV-associated mortality continues to decline, with an estimated 20,374 deaths due to HIV in 2019. Although both annual deaths among PLHIV and new HIV infections are decreasing,

the incidence-mortality ratio is still >1 with greater new infections than deaths due to all causes annually among people living with HIV (Figure 2.1.2).

Kenya has made significant progress toward HIV epidemic control. By the end of December 2019, there were 1.16 million PLHIV on ART nationally, of whom 1,137,111 were enrolled in PEPFAR-supported facilities (Figure 2.1.1). Community-level viral suppression among adults aged 15-64 years was 72.9%, while 79.5% of those who were tested positive knew their HIV status, 96% of those with known HIV status were on antiretroviral treatment, and 90.6% of those on HIV treatment had suppressed VL results (KENPHIA, 2018). Comparatively, among children aged 0-14 years, 78.9% with HIV infection knew their status, 93.2% of these were on ART, and 67.1% of children on ART had a suppressed VL (Table 2.1.2). This cascade shows that, in Kenya, the biggest gap is in case identification among all age groups and VL suppression among children. Notably, there is substantial variation in ART coverage across counties, ranging from 36% in Turkana county to 93% in Nairobi county (Spectrum 2020 estimates).

COP20 will continue to build on the strength and strategies of COP19 to accelerate progress toward HIV epidemic control. The overarching shift will be to tailor strategies based on programmatic, survey, and Spectrum data, both by population and by county. The program has tailored strategies to ensure that each county not only increases ART coverage based on the Spectrum 2020 estimates, but also stays on trajectory toward community-level suppression through client-centered approaches that not only keep recipients on care on treatment but also meets them where they are with what they need.

**Service Delivery Shifts as Tailored to Cascade**

| Cascade | Service Delivery Shifts |
|---|---|
| Testing and case identification | • Implementation of a public health approach through recency and case-based surveillance for high and medium ART coverage counties<br>• Continued efforts to optimize testing efficiency through eligibility screening as well as symptom and risk-based testing<br>• Robust emphasis on implementing index testing through a voluntary and rights-based approach (e.g. ensuring the 5 Cs: consent, confidentiality, counselling, correct results, and connection referral and linkage) |
| Linkage to treatment | • Proactive case management increasing HRH investment in linkage officers and repurposing some of the HIV testing services (HTS) counselors to proactively focus on linkage to treatment.<br>• Proactive linkage of treatment of infants identified through EID |
| Durable engagement and retention to care | • Shift in policy environment to enable recipients of care to have options on multi-month dispensing (MMD) of up to 6 months<br>• Increased external drug pick-up options including through the private sector |

| | |
|---|---|
| | • Increased coverage of and support to responsive mobile digital platforms that enhance retention through appointment reminders building on existing MOH platforms<br>• Engagement of local communities, FBOs, and networks to address stigma and improve retention<br>• Repurposing of HTS HRH investment for retention |
| Viral load suppression | • Optimization of treatment regimens to more efficacious and durable regimens: dolutegravir (DTG) for adults and children >20kgs, lopinavir/ritonavir (LPV/r) for all children <20kgs<br>• Engagement of local communities, FBOs, local social services and networks to address stigma and improve treatment coverage for children and retention<br>• Deliberate shift to ensure caregiver literacy for those with very young children is in place and implemented with fidelity<br>• Full scale implementation of peer-led interventions to increase VL suppression among adolescents including Operation Triple Zero (OTZ), an asset-based innovation to empower adolescents to have zero missed appointments, zero missed pills, and zero VL |

### 2.1.2 Maternal-to-Child Transmission (MTCT)

An estimated overall MTCT rate of 11% (Spectrum 2020 estimates) is unacceptable. Elimination of MTCT (eMTCT) remains a key goal of Kenya's HIV epidemic response. Of women attending first antenatal care (ANC 1) in FY19, 99% knew their HIV status and 98% of those who were identified as HIV positive initiated ART. Early infant diagnosis (EID) coverage improved due to enhanced post-natal HIV retesting and HIV-exposed infants (HEI) identification at immunization clinics. Of the 58,802 EID tests, 81% were tested at the recommended age of < 2 months, 1,715 (2.9%) were identified PCR positive, and 87% were linked to treatment.

Despite these good indicators, the estimated overall MTCT rate remains high at 11% (Spectrum 2020 estimates). A review of program data indicates that 50% of infant HIV infections occurred in 7 high-burden counties, with lower MTCTs rate of ~9% (APR19). The medium- and low-burden counties had higher MTCT rates but, overall, contributed to a lower number of new HIV infections. Based on the Spectrum estimates, 91% of infant HIV infections were due to mothers dropping off ART (47%, thus highlighting the importance of improving retention in PMTCT programs), acquiring HIV infection during the pregnancy or breastfeeding period (23%), or not initiating ART (21%). Based on the national positive infant PCR audit, while only 30% of HIV positive pregnant or breastfeeding women (PBFW) were newly diagnosed with HIV, they contributed 63%, of infant HIV infections diagnosed in the EID program. Additionally, young women, those who did not attend ANC, and those who started ART late (e.g. during the postnatal period) were all at increased risk of MTCT. Understanding contextual factors and community engagement will be critical in tailoring interventions in COP20.

The program will continue to utilize the national eMTCT framework launched in 2017 which provides an opportunity to close these gaps in COP20. Specific strategies informed by root cause analysis will be implemented to improve retention and viral suppression of PBFW on ART as well as early identification and linkage to follow-up of HEI. This will include strengthening referrals and linkage to OVC programs for additional support. In addition, women at high risk of HIV infection including PBFW will be prioritized for prevention interventions such as PrEP and layered DREAMS interventions. Improving EID coverage will remain a priority in COP19, with an increased focus on early testing of HEI who are aged <2 months through enhanced retention, post ANC 1 retesting and referral, and HEI screening at immunization.[1]

### 2.1.3 Orphans and Vulnerable Children (OVC) and Children Living with HIV/AIDS (C/ALHIV)

The 26% contribution of new HIV infections by females aged 15-24 years poses a threat to Kenya's most valuable future resource: youth. In COP20, the OVC program aligns geographically both to HIV burden and OVC unmet need. Similarly, in response to the COP20 guidance, of the total 711,471 OVC targeted aged <17 years, PEPFAR Kenya will target 46% (330,813) of OVC with known risk factors with a comprehensive family-centered case management program. Beneficiaries with known risks include C/ALHIV, children of PLHIV, HEI, children of female sex workers (FSW), survivors of sexual violence, and HIV positive adolescent and young mothers. The program will also target 31% (216,000) boys and girls aged 9-14 years with primary HIV and violence prevention to mitigate the risks using evidence-based materials and links to appropriate services. Further, 23% of at-risk adolescent girls will be reached with a comprehensive package of services through DREAMS layering and integration with the OVC program. To ensure CLHIV receive comprehensive support, the OVC program shall work with all the OVC implementing partners to develop MOUs which link clinical partners and health facilities and strengthen bi-directional referrals, joint case conferencing, age-appropriate disclosure, retention, and adherence.

The comprehensive OVC program is resource intensive both in funds and time. It applies family-centered approaches through systematic case plan management and outcomes monitoring for OVC and their households using guidance and tools that are aligned to benchmarks for OVC programming in Kenya. In COP20, the program will strengthen relationships and coordination with the clinical partners to increase the proportion of C/ALHIV on ART enrolled in the OVC program. Kenya has demonstrated steady enrollment of C/ALHIV - from ~45,000 in APR19 to the current 57,000 (53%) of eligible pediatric and adolescents patients on ART - and anticipates enrolling at least 90% by the end of FY21. Similarly, it is evident that C/ALHIV enrolled in the OVC program have better VL suppression (88%).

[1]The program began reporting on the correct denominator in FY19, based on MER Indicator Reference Guide Version 2.3 FY19

PEPFAR Kenya will ensure that 100% of OVC IPs have Memoranda of Understanding (MOU) with clinical facilities with clear roles and responsibilities and understand the OVC program in their geographical coverage area so that OVC services are offered by local IPs to facilitate cross-referrals and case-management. These MOUs will be put in place by September 30, 2021 and will involve all IPs that receive OVC funding. COP20 will promote shared confidentiality and consent to dispel fears among those declining to be enrolled in the OVC program. In collaboration with the clinical facilities, PEPFAR Kenya will promote the use of linkage coordinators stationed especially in high volume sites to ensure no eligible C/ALHIV has been missed out, especially those patients who are newly identified. PEPFAR Kenya will work closely with comprehensive care centers (CCC) and maternal child health (MCH) and PMTCT clinics to ensure HIV positive caregivers (including adolescents and young mothers with non-adherence issues likely to affect C/ALHIV under their care) are identified and tracked for better case management. COP20 will support the building of caregiver parenting skills, as well as skills with respect to the care of HIV-affected, infected, and exposed children and adolescents. COP20 will further seek to empower caregivers through evidence-based household and group-based economic strengthening interventions and links to existing social safety net programs and other resources.

Funding gaps still exist to adequately support OVC service delivery both at national and county level, and to support existing county children's structures at community level such as county and sub-county Area Advisory Councils (AACs). In addition, there is weak coordination of stakeholders both at national and county levels, leading to duplication of efforts, poor reporting, and poor quality of services. All these pose challenges to providing comprehensive services within the constrained investment and fast-tracking transition of OVC households from PEPFAR to sustainable support. PEPFAR will continue to support county policies and strategies that allocate resources and investment for at-risk OVC and their families and promote their rights, protection, and welfare. PEPFAR Kenya, through collaboration between the concerned county authorities and the COP19 lead IP, will develop county transition plans to ensure follow up and close monitoring of C/ALHIV in the 14 counties that PEPFAR will be transitioning out of in order to ensure gains are sustained beyond COP 19.

### 2.1.4 Adolescent Girls and Young Women (AGYW)

In order to address the continued high HIV incidence among AGYW, Kenya implements the DREAMS program through the provision of evidence-informed, age-appropriate layered services for HIV prevention, as well as prevention and response to violence among AGYW aged 9-24 years. In COP20, the program will increase coverage within the current DREAMS counties (Homabay, Siaya, Kisumu, Migori, Nairobi, Kiambu, and Mombasa) aiming for 100% ward coverage so as to reach 321,491 AGYW. This is a 28% expansion from an annual target of 252,000 in COP19. The program will strengthen completion of the required layered primary and secondary package of services and expand implementation to reach saturation of the at-risk and most vulnerable AGYW at the following levels: at least 75% saturation in Kisumu, Siaya, Homabay, Migori, and Mombasa; 50% saturation for

Kiambu in view of reduced incidence and program implementation experience; and 60% saturation in Nairobi to reflect an urban model. These levels also position the county for 75% saturation in COP21. The PEPFAR DREAMS program will work closely with the Ministry of Health, NAC, GF recipient partners, and other stakeholders to discuss and explore existing opportunities for saturation and facilitate geographic expansion and saturation.

### 2.1.5 Voluntary Medical Male Circumcision (VMMC)

Since 2017, Kenya has been working toward an ambitious annual target to achieve VMMC saturation in males aged 15-29 years while expanding services for boys aged 10-14 years. With the available evidence that conventional surgical circumcision among boys aged <15 years is associated with a higher risk of glans injuries and urethral fistula and confers distal HIV prevention benefit, VMMC targets in COP20 will be limited to males aged ≥15 years. Based on historical performance and the number of circumcisions needed to achieve saturation in the 15-29-year age band, the national VMMC target will further decline; from 300,000 in COP18, to 200,000 in COP19, to 54,844 in COP20. In COP20, two VMMC focus counties that have reached 90% male circumcision (MC) coverage in the 15-29-year age band (Nakuru, Busia) will be transitioned out of PEPFAR support. Six counties with MC coverage below 90% (Turkana, Kisumu, Homabay, Siaya, Migori, Nandi) will receive comprehensive PEPFAR funding. Nakuru and Busia will be transitioned out of PEPFAR support by supporting the development of county transition plans to ensure gains are sustained beyond COP19.

### 2.1.6 Key Populations (KP) and Priority Populations (PP)

Kenya's National AIDS and STI Control Program (NASCOP) has recognized the following categories of KP in Kenya: female sex workers (FSW), men who have sex with men (MSM), the transgender population (TG), and people who inject drugs (PWID). In recognizing their HIV prevalence and incidence, along with their vulnerability and contribution to the national HIV epidemic, Kenya has categorized fisherfolk and populations in prisons and other enclosed settings as high-risk priority populations (PP) deserving tailor-made HIV programming.

Over the years, KPs and PPs have had high HIV prevalence rates, ranging from estimates of 18.2% among MSM, 29.3% among FSW, and 18.3% among PWID (IBBS, 2011). Fisherfolk in the lake region of western Kenya constitute a PP with an estimated 23.4% HIV prevalence (KEMRI Asembo Fisherfolk IBBS, 2016). These demographic and epidemiological data are summarized in Table 2.1.1 and Table 2.1.2 below.

In 2018, the first phase of a PEPFAR-funded size estimation activity led by NASCOP provided updated estimates of KP sizes based on programmatic mapping: 32,580 MSM 167,940 FSW, and 16,063 PWID. (NASCOP, KPSE phase I report, April 2019) A respondent-driven sampling (RDS) approach is being utilized in the ongoing Phase II size estimate. Since the estimates were based on the existing program reach, PEPFAR Kenya inferred 1% of all men aged 15-64 years are likely to identify as MSM. This increased the PEPFAR Kenya

MSM targets to 80,064 in the 24 priority sub-national units (PSNU) where the program is intended to be implemented. Discussions are underway between the KP CSOs, the Ministry of Health, USG agencies, and other stakeholders on integrated biological and behavioral surveys (IBBS) or other alternatives to provide current epidemiological data to improve KP programing for epidemic control,

The PEPFAR-supported KP program provides a comprehensive package of biomedical and behavioral services for prevention, diagnosis, and treatment of HIV, sexually transmitted diseases, and viral hepatitis. Despite availability of services, uptake remains suboptimal, largely because of stigmatization and criminalization of KP behavior. ART coverage through KP-friendly services is estimated at about 50% in all three populations. To address these gaps, PEPFAR invests in the sensitization of health workers and relevant authorities, as well as KP community engagement approaches, including funding of KP-led and competent organizations to deliver services directly to community members and regular CSO stakeholder engagement for program guidance. The KP program has been redesigned through ambitious targets and resource allocation with an intention of meeting the 95:95:95 goal by 2025.

In COP20, PEPFAR will continue working with the Ministry of Health to create an enabling environment for KPs to access health services through policy development and review especially targeting the transgender community. In addition, PEPFAR will continue building strong partnerships with the KP Consortium, and Trans* organizations through structured periodic engagements to ensure the KP program is owned and managed by KPs. Achieving sustained epidemic control will be predicated on achieving optimal coverage of clinical and prevention interventions as well as on strengthening the national sustainability profile and leveraging transformative health systems investments. PEPFAR will support the KP Consortium to engage, sensitize, and strengthen the capacity of county and national administrative instruments on KP-related health and human rights issues in an effort to address the legal and structural barriers impacting the sustainability of KP program achievements.

**Key Populations led organization** is a community-led organization led, run and managed by either sex workers (SWs), gay men and other men who have sex with men (MSM), transgender people (TG), and people who inject drugs (PWID) who are mostly disproportionately affected by HIV, stigma, discrimination, and threat of criminal prosecution , violence , hostile environment and mental health.

**Key Populations competent organization** is a non-KP-led organization implementing key populations programs. Such organizations or programs engage KP peer educators to create demand for services and provide clinical services through drop-in centers or through government health facilities. KP-competent organizations have institutional mechanisms for recruiting members of the KP community to specific positions within the program or organization, For instance, at the International Center for Reproductive Health, recruitment of community mobilizer positions and administrative assistant positions we

specifically recruit members from the KP communities served (FSW, MSM and transgender). All the organization's staff (all staff carders including support staff) undergo sensitivity training for KP programming.

### 2.1.7 Pre-exposure prophylaxis (PrEP)

In COP20, PrEP will be scaled up among AGYW and KPs while also expanded to other populations who are at increased risk of HIV. A total of 267,044 AGYW aged 15-24 years will be targeted with PrEP information, education, and communication (IEC). An estimated 28,671 AGYW (aged 18-24 years) will be newly initiated on PrEP. Additionally, 23,632 FSW, 23,384 men aged 15-64 years who are at increased risk of HIV acquisition, 9,956 MSM, 8,459 PBFW, 5,279 sero-discordant couples, 311 TG, and 310 PWID will also be initiated on PrEP. Key priorities will include integration of PrEP into mainstream health services provision, orientation of facility staff, demand creation (use of champions, social media, IECs), training, capacity building and mentorship, and data capture, monitoring, and reporting. Community sensitization to reduce myths and misconceptions around PrEP and to increase demand among all eligible populations will also be enhanced.

## Table 2.1.1 Host Country Government Results

| | Total | | <15 | | | | 15-24 | | | | 25+ | | | | *Source, Year* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Female | | Male | | Female | | Male | | Female | | Male | | |
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % | |
| Total Population | 47,564,296 | 100 | 9,208,427 | 19 | 9,333,055 | 20 | 4,934,220 | 10 | 4,798,954 | 10 | 9,871,772 | 21 | 9,415,661 | 20 | KNBS, 2019 Census Vol III |
| HIV Prevalence (%) | | 4.5 | | 0.6 | | 0.6 | | 2.4 | | 1.4 | | 7.9 | | 4.6 | Spectrum 2020 estimates (total for 15-49 years) |
| AIDS Deaths (per year) | 20,374 | | 2,126 | | 2,232 | | 1,380 | | 1,272 | | 6,231 | | 7,136 | | Spectrum 2020 estimates |
| # PLHIV | 1,511,612 | | 49,930 | | 50,512 | | 100,154 | | 48,957 | | 805,985 | | 456,073 | | Spectrum/Naomi 2020 estimates (Projected to Sep, 2020) |
| Incidence Rate (Yr) | | 0.11 | | | | | | 0.21 | | 0.08 | | | | | Spectrum/Naomi 2020 estimates (Projected to Sep, 2020) |
| New Infections (Yr) | 40,825 | | | | | | | | | | | | | | Spectrum 2020 estimates |
| Annual births | 1,405,222 | | | | | | | | | | | | | | Spectrum 2020 estimates |
| % of Pregnant Women with at least one ANC visit | | 97.3 | | | | | | 97.4 | | | | 97.3 | | | KENPHIA 2018 (% with 1+ ANC visit during last pregnancy up to 3 years prior to survey) |
| Pregnant women needing ARVs | 62,769 | | | | | | | | | | | | | | Spectrum 2020 estimates |
| Orphans (maternal, paternal, double) | 2,055,420 | | | | | | | | | | | | | | Spectrum 2020 estimates (0-17) |
| Notified TB cases (Yr) | 84,711 | | 3,808 | | 4,398 | | 6,058 | | 8,902 | | 20,061 | | 41,484 | 84,711 | National TB Program data, 2018 |
| % of TB cases that are HIV infected | | 26 | | 14 | | 15 | | 16 | | 8 | | 42 | | 25 | National TB Program data, 2018 |
| % of Males Circumcised | | 91.7 | | | | | | | | 90.4 | | | | 92.7 | 2018 KENPHIA, overall is for 15-64, |
| Estimated Population Size of MSM* | 84,277 | | | | | | | | | | | | | | 2018 KP size estimate |
| MSM HIV Prevalence | | 18 | | | | | | | | | | | | | 2018 KP size estimate |
| Estimated Population Size of FSW | 167,940 | | | | | | | | | | | | | | 2018 KP size estimate |
| FSW HIV Prevalence | | 29 | | | | | | | | | | | | | 2018 KP size estimate |
| Estimated Population Size of PWID | 16,063 | | | | | | | | | | | | | | 2018 KP size estimates |
| PWID HIV Prevalence | | 18 | | | | | | | | | | | | | 2018 KP size estimate |
| **1.**Fisherfolk<br>**2.**Prisoners<br>**3.**Uniform-ed services<br>**4.**Military<br>**5.**AGYW aged 15-19<br>**6.**AGYW aged 20-24 | **1.** 123,065<br>**2.** 85,273-200,000<br>**3.** 108,000<br>**4.** 30,000<br>**5.** 2,498,353<br>**6.** 2,234,644 | | | | | | | | | | | | | | Data presented are for targeting purposes and may not reflect actual size.<br>Sources various including: Fisherfolk: FELTP AA 2011, AGYW: KNBS 2019 Census<br>Others: NASCOP KPSE Consensus Report |
| Estimated Priority Populations Prevalence: Fisherfolk | | 33.8 | | | | | | | | | | | | | Fisherfolk: IBBS 2018 among island fisherfolk, |

**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table. Cite sources*

## Table 2.1.2 95-95-95 cascade: HIV Diagnosis, Treatment and Viral Suppression

| Epidemiologic Data | | | | | HIV Treatment and Viral Suppression | | | HIV Testing and Linkage to ART Within the Last Year | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Total Population Size Estimate (#) | HIV Prevalence (%) | Estimated Total PLHIV (#) | PLHIV diagnosed (#) | On ART (#) | ART Coverage (%)* | Viral Suppression (%) ** | Tested for HIV (#)*** | Diagnosed-ed HIV Positive (#)*** | Initiated on ART (#) |
| Total population | 47,564,296 | 3.2 | 1,511,612 | 1,338,445 | 1160479 | 77 | 91 | 10010348 | 185065 | 167922 |
| Population <15 years | 18,541,482 | 0.6 | 100,443 | 72,968 | 71516 | 67 | 79 | 716053 | 7107 | 7393 |
| Men 15-24 years | 4,798,954 | 1.0 | 48,958 | n/a | 27,371 | 56 | 79 | 1020237 | 8632 | 6581 |
| Men 25+ years | 9,415,661 | 4.8 | 456,073 | n/a | 318,555 | 69 | 92 | 2169899 | 56241 | 53936 |
| Women 15-24 years | 4,934,220 | 2.0 | 100,154 | n/a | 62,376 | 61 | 79 | 1777483 | 16771 | 24082 |
| Women 25+ years | 9,871,772 | 8.1 | 805,985 | n/a | 679,209 | 84 | 92 | 3127210 | 79148 | 75930 |
| | | | | | | | | | | |
| MSM | 84,277 | 18 | 15,176 | *n/a* | *n/a* | *n/a* | *n/a* | *n/a* | *n/a* | *n/a* |
| FSW | 167,940 | 29 | 41,606 | *n/a* | *n/a* | *n/a* | *n/a* | *n/a* | *n/a* | *n/a* |
| PWID | 1,721 | 18 | 310 | *n/a* | *n/a* | *n/a* | *n/a* | *n/a* | *n/a* | *n/a* |
| PP - Fisherfolk | 123,065 | 34 | n/a | n/a | n/a | 77 | 84 | n/a | n/a | *n/a* |

*Estimated national ART coverage as of Dec, 2019.
** Program/survey VLS among patients on ART
***Tested for HIV excludes 1,199,466 women tested for HIV for PMTCT for which age disaggregation not available, HIV positive excludes 17,166 women diagnosed through PTCT for which age disaggregation not available through DHIS.

Sources: Population – 2019 Census, PLHIV Estimates – spectrum estimates, On ART – DHIS, Jul-Dec 2019, viral suppression – national VL database Dec 2019, Testing and linkage DHIS KP population estimates by NASCOP

**Figure 2.1.3 Updated National and PEPFAR Trend for Individuals Currently on Treatment**

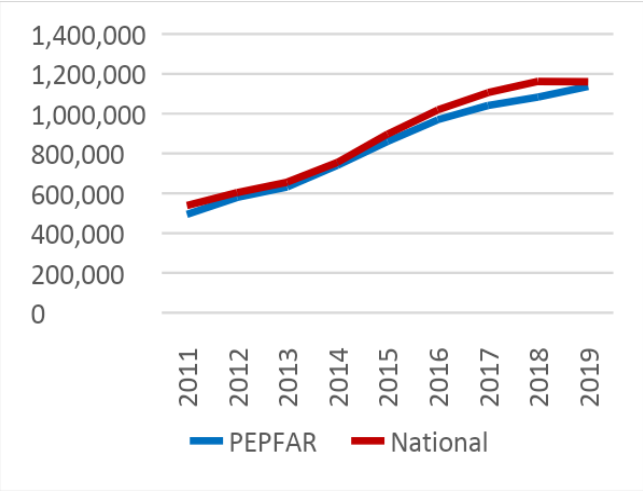



**Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV**

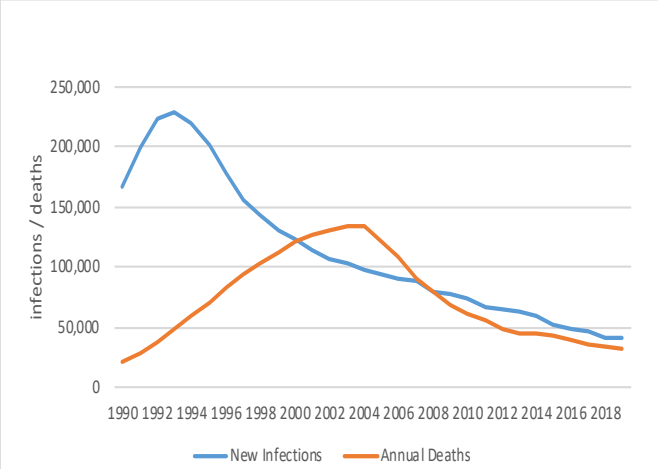



**Figure 2.1.5. Progress retaining individuals lifelong ART in FY19**

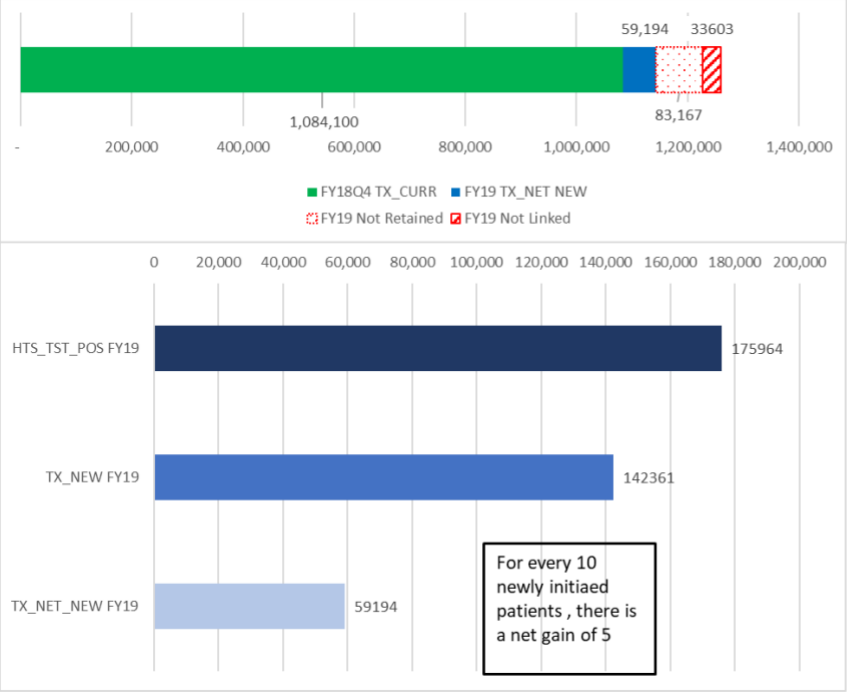



**Figure 2.1.6 Proportion of clients lost from ART 2018 Q4 to 2019 Q4**

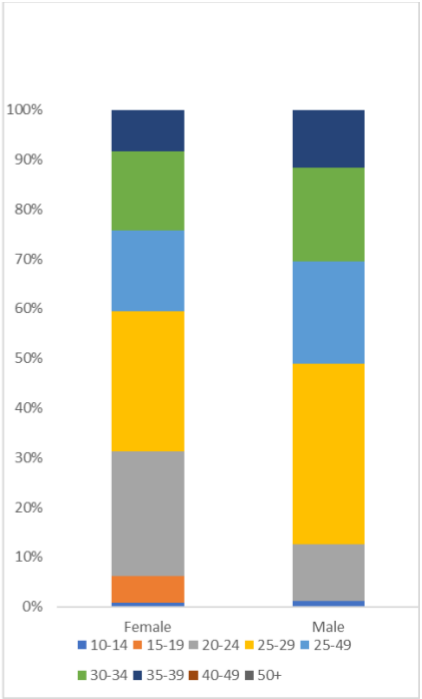


**Figure 2.1.7 Epidemiologic Trends and Program Response in Kenya**

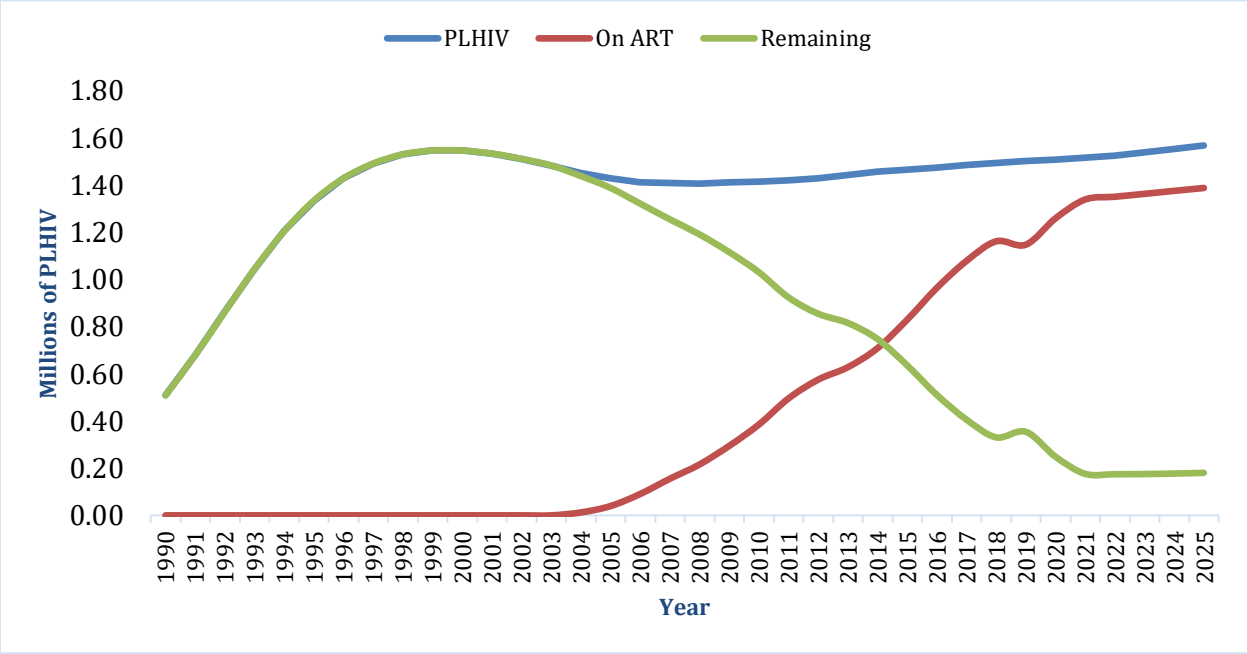
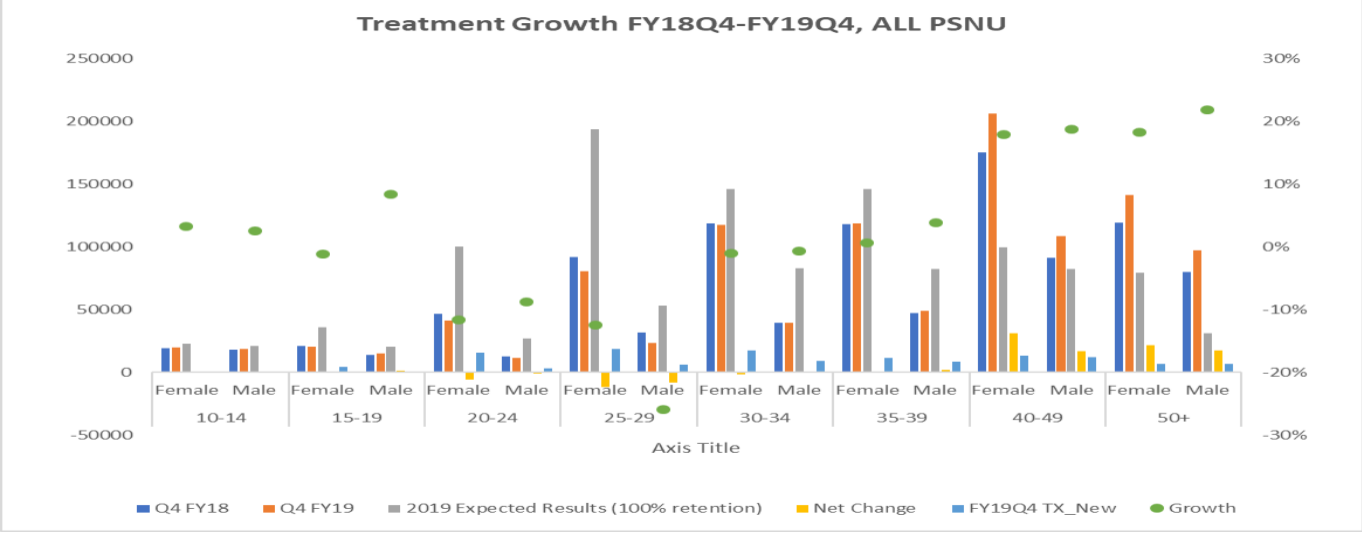



Figure 2.1.8 shows the HIV treatment growth by age/sex in order to pinpoint where there are specific areas of intervention needed to maintain and grow the HIV treatment population.

**Figure 2.1.8 Net change in HIV treatment by sex and age bands 2018 Q4 to 2019 Q4**



### 2.2 New Activities and Areas of Focus for COP20

In COP20, PEPFAR Kenya will continue to support the GOK and its partners to improve client retention especially for men <30 years of age on treatment, AGYW, and PBFW by strengthening proven linkage and retention strategies . It will also prioritize VL suppression through demand creation for VL testing and optimized use of VL results for patient management, as well as improve access to Dolutegravir (DTG).

#### 2.2.1 Strengthened Client Linkages for Retention

Retaining individuals on lifelong ART and bringing back to care those who are lost to follow-up will be a key intervention for PEPFAR in COP20 (Figures 2.1.3, 2.1.4). PEPFAR Kenya will work with communities, FBOs, and CSOs to trace those lost to follow-up and relink and retain them on lifelong treatment, with a special focus on the young and healthy individuals who are at a higher risk of being lost.

The majority of clients lost to follow-up have been those who are newly initiated on ART. Thus, all clients testing positive will be physically escorted to the clinician's desk and handed over to initiate treatment. Pretreatment assessment will be done to determine who needs what type of support and each client will be linked to services appropriately. COP20 will strengthen treatment preparation sessions beyond the initial pre-ART session so as to walk with clients through their first year of ART. Case management will be provided for all new clients with an emphasis on those with special needs identified in the pretreatment assessment.

COP20 will support the engagement of youth mentors to act as case managers to their peers. There will be a well-defined support system structure where issues beyond the ability of the case manager may be addressed by trained counselors, clinicians, medical consultants, and social workers. Periodic client satisfaction interviews will be done with the aim of addressing client-specific gaps in management and making the HIV treatment program attractive to clients. COP20 will also support the employment of both proactive and reactive measures to ensure minimal missed appointments and rapid re-engagement into treatment for those falling out. Use of technology with bulk SMS reminders and Ushauri automated appointment and default tracing systems will be sustained.

In COP20, PEPFAR Kenya will support implementation of a private sector engagement initiative which entails a decentralized drug distribution system to improve retention and offer clients choices with respect to when and from where to collect drugs, with data informing scale up. PEPFAR Kenya, through USAID, is leveraging Sustainable Financing Initiative (SFI) funds to lay the groundwork for scaling up client-centered care and the decentralization of drug distribution. SFI funding is currently being used in three counties (Nairobi, Busia, and Kajiado) to determine the potential of private institutions as drug distribution sites and their ability to serve as pick-up points. The pilot project is also testing consumer interest across a range of indicators to better understand how and where to quickly start scaling up decentralized drug distribution in COP20. The Ministry of Health

will play a key role ensuring effective supply chain management, data capture, and reporting both for drugs and services.

COP20 will also support implementation of continuous quality improvement (CQI) and root cause analysis, linked to appropriate response by partners. Prior research on people lost to follow-up has shown health care worker attitudes toward HIV clients and perceived maltreatment as stumbling blocks to retention. These issues are being addressed through continuous health care worker training and monitoring on attitude change in collaboration with CSOs. Return-to-care packages have been developed and will be provided for clients previously disengaged from treatment who are returning. The aim is to ensure the issues, fears, and concerns that led to loss to follow-up are addressed as they restart their treatment. Case management will be done for all clients returning to care with appropriate case managers chosen to address individual clients' needs.

PEPFAR will also work to ensure there is adequate linkage between the facility and communities for both data capture and referrals. Linkage registers and facility referral tools will be used to track and facilitate follow-up alongside complementary support to develop monitoring and evaluation instruments including ART distribution forms, fast-track forms, and registers.

### 2.2.2 Differentiated Service Delivery Models for Retention

One of the proven strategies to retain patients is to expand differentiated care by frequency of service. PEPFAR Kenya has been implementing differentiated service delivery models since 2017, which has reduced the transaction costs for patient travel to facilities, increased peer support and community involvement, reduced workload for health workers, and maintained and improved patient outcomes.

COP20 will strengthen differentiated service delivery models that respond to the needs of clients, taking care of special subpopulations like older working men, school-going children, and young adults with flexible clinic operating hours. Clinic operating hours will be extended beyond the 8-5 time period to open early and close late to serve populations working or in school during the official working hours. In addition, weekend clinics will be operated to serve those busy or out-of-location during weekdays.

The facility fast track model is the most popular model of choice by clients on differentiated care in Kenya. COP20 will support improving this model by minimizing time spent by clients, setting a target of 30 minutes in and out of the facility. In high volume facilities, drug dispensing booths will be established to ease the client flow and congestion experienced in these facilities during drug pick up days. Peer mentors will be mentored and deployed in these booths to dispense the drugs and ease the strain on pharmacists. Community ART groups will take HIV services closer to the clients ensuring their life goes on as uninterrupted as possible. Different community ART distribution models will be implemented to give clients many options to choose what suits them. For youth, distribution by their peers will be scaled up in all regions of the country. PEPFAR Kenya

program is already doing multi-month prescriptions and dispensing (MMD). Discussions have been initiated with the Ministry of Health to have a policy allowing up to six months dispensing of ART and this is expected to be reflected in the 2020 ART guidelines due for release in mid-year. As part of patient-centered care, treatment literacy will continue to be offered to stable patients in differentiated models.

### 2.2.3 Promote Positive Health, Dignity and Prevention (PHDP) for Retention

In COP20, Kenya will intensify and scale up PHDP interventions and patient literacy to all PLHIV aged >15 years and their caregivers at HIV clinical settings and in the community to prevent onward transmission of HIV, as well as to maintain the health of patients. PHDP interventions will be delivered by health care providers, counselors, and peer educators. Services will include risk reduction, sexually transmitted infection (STI) screening, family planning (FP) counselling, pregnancy intention and assessment screening to add to the family planning services, adherence and retention interventions, knowledge of status, partner testing, disclosure counselling, as well as psychosocial support groups for all PLHIV. Meaningful involvement of PLHIV (MIPA) to enhance adherence and retention will be scaled up including peer models such as mentor mothers, adolescent and adult peer mentors, PHDP and evidence-based medication adherence interventions such as Operational Triple Zero (OTZ) at both facility and community levels. Adolescents and young people (AYP) aged ≥15 years will receive both OTZ and PHDP interventions.

### 2.2.4 Viral suppression

PEPFAR Kenya continues to report improved suppression with overall viral suppression at 92% as of FY20 Q1. Across age groups, clients aged >50 years have achieved the target suppression of 95%, with adults aged > 25 years having suppression of 93%. Challenges remain in suppressing children, adolescents, and young adults with suppression of children aged 0-15 years and 15-24 years at 80% and 85% respectively. There is also varying performance among counties: 3 counties have a suppression of less than 85%, 14 counties have suppression of 86% to 90%, and 23 counties have suppression over 90%. The 3 counties with suppression of less than 85% have similar characteristics being vast semi-arid counties inhabited by highly mobile pastoralist communities. For COP20, focus will be on improving suppression among children, adolescents, and young persons while maintaining the successful strategies used in adults to maintain suppression rates. COP20 will strengthen access to VL testing and improve VL suppression through demand creation for VL testing services and optimized use of VL results for patient management. The program will also transition to optimal DTG and LPVr regimen for children as one of the principal strategies to improve VLS in children.

### 2.2.5 Scale Up of Dolutegravir

As of the end of FY20 Q1, more than 500,000 PLHIV were receiving Dolutegravir (DGT) as per the 2018 ART guidelines and the July 2019 NASCOP circular that allowed for use of DTG in women of reproductive age. These guidelines are currently under revision and DTG use will be explicitly captured as part of the revision. In FY20/21, Kenya will continue to scale up use of DTG per the WHO guidelines in combination with other appropriate treatment

molecules. Kenya is already using DTG for the pediatric population and nevirapine phase out is well under way with the very small number of clients currently on nevirapine expected to transition to appropriate regimens by the start of COP20.

### 2.2.6 Additional Areas of Focus for COP20

COP20 will continue to support nutrition assessment counseling and support (NACS) and therapeutic feeding for severe acute malnutrition (SAM), cryptococcal meningitis screening, and ART monitoring as per national 2018 guidelines. In addition, COP20 will prioritize TB prevention and treatment through optimized TB screening, use of newer, efficacious and shorter regimens such as 3HP, improved diagnosis using GeneXpert and TB-LAM, and IPT among all eligible PLHIV. It will contribute to both pharmacovigilance and HRH strengthening.

## 2.3 Investment Profile

The GOK remains committed to ending AIDS by 2030, making strategic investments in health to maximize impact while increasing domestic resources to sustain the national HIV/AIDS response. The GOK's prioritization of affordable healthcare for all under the universal health care (UHC) agenda will advance progress to ensure equitable and affordable access to quality essential health services, particularly for the disadvantaged, vulnerable, and poor in Kenya, including people living with or affected by HIV.

The current health financing landscape indicates an improvement in government financing to the health sector. The proportion of total government budget allocation to health for both national and county levels has started showing improvement at 9.2% in Kenya Fiscal Year (KFY) 2018/19 after decreasing significantly from 7.8% before devolution in KFY 2012/13. However, out-of-pocket spending still remains a large source of health financing (accounting for 32.8% of total health spending in 2015/16), placing vulnerable households at greater risk of incurring catastrophic or impoverishing health expenditures (estimated at 4.9% in 2015 down from 6.2% in 2013).

Funding to the health sector remains limited. The large proportion of government revenue used to finance debts and wages, coupled with slow economic growth and demand from other competing sectors, limit the expansion of health resources. The clamor for higher wages by public sector employees resulting in ongoing nationwide health worker strikes has contributed to the ballooning public wage bill (52% of government revenues in KFY2017/18), leaving few resources to be used for health or other services.

While public sector contributions to HIV/AIDS have increased from 18.8% in KFY 2012/13 to 22.1% in KFY 2015/16, donors remain the predominant source of HIV financing, contributing 62.3% of HIV expenditures in KFY 2015/16. PEPFAR Kenya represents 76.8% of annual total investments across all HIV program areas (Table 2.3.1). Households via out-of-pocket spending (9%) and employers (6.5%) have been excluded in the computation in Table 2.3.1. Kenya's contribution as part of its GF counterpart-financing requirement was $22 million in KFY 2017/18 and is expected to increase to $39 million in 2020/21, as shown

by the budget estimates for the National Treasury and Ministry of Health that have been presented to the National Assembly. Nevertheless, donors continue to finance the majority of ARVs (75% in KFY 2019/20 down from 86.4% in KFY 2018/19) and all HIV test kits in Kenya (Table 2.3.2).

On average, county governments increased the proportion of their total budgets allocated to health from 13.0% in KFY 2013/14 to 27.2% in KFY 2018/19 (increasing to 27.8% in 2019/20) reflecting the extent to which county governments prioritize health investments over other sectors. Anticipated increases in salary increments resulting from the ongoing labor disputes are expected to significantly impact county allocations to health. However, current efforts to rationalize staff and clean up payroll will help contain the wage bill (currently 75.8% of county allocations in KFY 2018/19) thereby freeing up resources to finance drugs, medical supplies, and other critical health service delivery inputs.

Significantly greater domestic financing for health and HIV is needed to reduce donor dependency and sustain progress made in controlling the HIV epidemic. Increased government budget alone is inadequate to offset uncertainties in donor support. Efforts to increase the fiscal space for health must be accompanied with measures to address inefficiencies in the use of available resources, including health insurance reforms and other measures that could ensure greater returns on investment. Innovative financing such as engagement with the private sector will continue to be explored to expand uptake of HIV services, decongest the public sector, and ensure long-term sustainability of the HIV response.

**Costing and Health in Kenya**

GOK is in the midst of developing its National and County AIDS Strategic Frameworks, as well as preparing for the next round GF application. The country is also just starting its next fiscal budgeting process. Sustainability will require payment levels for the current NHIF premiums to include HIV/AIDS in the benefit package, and the reimbursement process streamlined. External resources are off-budget and not included in the HIV/AIDS planning process (e.g. PEPFAR, CHAI, Gates Foundation, the Elton John AIDS Foundation); thus, to help encourage sustainability, these should be incorporated in national and county planning processes. Strengthened coordination between national and county government and stakeholders, as well as between intra-county stakeholders, is also required. Key areas of investment for domestic resource mobilization also remain, including technical and financial support toward both transition and strengthening of leadership responsibilities, as well as increased national and county GOK resourcing and recognition of the community workforce so as to reduce the HRH donor dependency ratio at community level.

Policymakers and partners involved in funding and managing HIV programs have a need for current information on how costs, financing, utilization, and performance of different patterns of delivery vary and the factors that affect them. Their ability to stay well-informed about costs and performance is limited by how the epidemic has evolved and complicated by variations in the rapid transformation of service modalities, including differentiated

care, availability of HIV-related services at the sub-national level, characteristics of the population of persons newly infected with HIV, and price changes. This swift pace of change means that existing, one-time cost data quickly become dated and are of limited use for decision-makers and management.

This highlights the need for cost analyses that reflect the significant changes to HIV care cascades in recent years and the need for a system that regularly collects data to produce information required for effective decision making on a routine basis. Simultaneously, the reduction of international assistance on health and competing demands for public funding have increased emphasis on transparency of expenditures, increased health spending efficiency, and performance measurement in HIV-related services.

To address these issues, the PEPFAR Kenya team in collaboration with the Ministry of Health, National Treasury, and Council of Governors is undertaking a process to implement an Activity-Based Costing and Management (ABC/M) system application in Kenya to obtain routine cost information on the provision of HIV and health services at facility, community, and above site levels and to use this information to effectively allocate resources, improve monitoring efforts, and increase efficiency. This type of data may be used by policymakers and partners to assist in making more evidence-based decisions for budgeting and resource allocation, and improving processes and resource use.

This activity requires a diligent process that will not only help confirm the true costs of programming and comprehensive health service delivery under UHC but also establish efficiency and barriers to the provision of services with fidelity. To this end, beginning in COP19, the PEPFAR Kenya Interagency Technical Team, the OGAC Headquarters Country and Accountability Team, and the USAID Headquarters Sustainability Team have been working in close collaboration with the Ministry of Health's leadership including the Chief Economist, the Planning and NACC Costing and KASF II Working Groups, and the National Treasury and Council of Governor's Health Team to develop a plan for a robust costing system. Through USAID, additional non-HIV funds from Gates Foundation to further support this process will ensure additional resources will be available for non-HIV and UHC costing aspects to be covered under this process. The goal is for Kenya to develop more financially sustainable and effective HIV and health care platforms.

**Table 2.3.1 Annual Investment Profile by Program Area**

| Program Area | TOTAL | PEPFAR | GF | GOK | Other |
|---|---|---|---|---|---|
| Care and Treatment | 244,138,620 | 73.4% | 16.8% | 9.9% | 0.0% |
| HIV Testing Services | 19,560,108 | 86.4% | 13.6% | 0.0% | 0.0% |
| Prevention | 74,097,744 | 67.3% | 18.4% | 14.2% | 0.0% |
| OVC | 31,214,070 | 94.1% | 5.9% | 0.0% | 0.0% |
| Above Site Programs | 22,840,950 | 79.9% | 20.1% | 0.0% | 0.0% |
| Program Management | 96,646,664 | 84.2% | 7.4% | 8.4% | 0.0% |
| **TOTAL** | **488,498,156** | **76.8%** | **14.5%** | **8.7%** | **0%** |

Source: MOH Printed Estimates 2019/2020; National Treasury Counterpart Estimates 2019/2020; Kenya Global Fund 2017 Application, NHA 2015/16
Note: Household and employer contributions excluded

**Table 2.3.2 Annual Procurement Profile for Key Commodities**

| Commodity Category | Total Expenditure | PEPFAR % | GF % | GOK % | Other % |
|---|---|---|---|---|---|
| PSM | 3,273,126 | 0% | 100% | 0% | 0% |
| Consumables | 1,048,928 | 0% | 100% | 0% | 0% |
| Rapid Test Kits | 7,208,387 | 69% | 31% | 50% | 0% |
| Viral Load | 14,858,416 | 100% | 0% | 0% | 0% |
| Laboratory Supplies | 3,283,941 | 82% | 18% | 0% | 0% |
| CD4 | 2,052,435 | 0% | 0% | 100% | 0% |
| Health Equipment | 0 | 0% | 0% | 0% | 0% |
| Medicines | 1,548,204 | 86% | 14% | 0% | 0% |
| Condoms and Lubricants | 2,969,170 | 0% | 100% | 0% | 0% |
| Antiretroviral Drugs | 100,725,629 | 43% | 32% | 25% | 0% |
| **TOTAL** | **134,915,801** | **50.0%** | **31.3%** | **18.7%** | |

Source: MOH Printed Estimates 2019/2020; National Treasury Counterpart Estimates 2019/2020; Kenya Global Fund 2017 Application.
Note: Rapid test kit expenditure is historical data based on expenditure in FY 2018/19.
Note: Household and employer contributions excluded.

**Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration FY20 (US$)**

| Funding Source | Total USG Non-PEPFAR Resources | Non-PEPFAR Resources Co-Funding PEPFAR IMs | # Co-Funded IMs | PEPFAR COP Co-Funding Contribution | Objectives |
|---|---|---|---|---|---|
| USAID MCH | 16,000,000 | 4,857,104 | 7 | 34,040,144 | Supporting quality services for maternal and child health |
| USAID TB | 5,000,000 | 3,962,549 | 4 | 5,169,502 | Improving TB diagnosis, care and treatment |
| USAID Malaria | 35,000,000 | 6,716,574 | 5 | 7,157,535 | Supporting malaria prevention and treatment is select high burden counties |
| USAID Family Planning | 20,500,000 | 6,750,000 | 9 | 77,636,589 | Support FP services in the country |
| Nutrition | 4,000,000 | 0 | 0 | 0 | Support nutrition interventions in the country |
| NIH | - | - | - | - | - |
| CDC (Global Health Security) | - | - | - | - | - |
| DOD HIV Research | 1,107,167 | | 2 | | Support AFRICOS HIV Cohort and Pediatric Viral Load Studies |
| DOD Lab Support | 27,457 | | 1 | | Support proficiency panels for CRC Lab |

| | | | | | |
|---|---|---|---|---|---|
| Quarantine | 234,143 | - | | | Surveillance of migrant populations and refugee camps |
| CDC DTRA | - | - | | | |
| Global Disease Detection and Emergency Response | 47,986 | 47,986 | 1 | | Building capacity, monitoring & detecting threats , responding to international emergencies and reconstructing health systems |
| Global Health Security: Program Costs | 2,388,957 | 2,388,957 | 1 | | Help develop health systems that prevent avoidable epidemics, early threat detection and rapid and effective response |
| Global Public Health Capacity Development | | 1,400,000 | 1 | | Global Health Protection research to KEMRI and MOH |
| Improving Program Effectiveness | 650,000 | 650,000 | 1 | | HIV AIDS clinical research |
| Malaria | 100,000 | 100,000 | 1 | | Malaria research |
| Pandemic Influenza | 498,412 | 1,438,500 | 1 | | Flu research |
| CDC OD | 1,738,213 | 148,286 | | | Management Support |
| Tuberculosis Research | 383,500 | 383,500 | | | |
| **Total** | **87,675,835** | **28,843,456** | **34** | **124,003,770** | |

## 2.4 National Sustainability Profile Update

Significantly greater domestic financing for health and HIV is needed to reduce donor dependency and sustain progress made in controlling the HIV epidemic. Increased government budget alone is inadequate to offset uncertainties in donor support. The GOK remains committed to ending AIDS by 2030, making for strategic investments in health to maximize impact while increasing domestic resources to sustain the national HIV/AIDS response. Further, the GOK's plan for prioritization of affordable healthcare for all under the universal health care (UHC) agenda will advance progress to ensure equitable and affordable access to essential health services, particularly for the disadvantaged, vulnerable and poor in Kenya, including PLHIV.

The 2019 Sustainability Index and Dashboard (SID) 4.0 and Responsibility Matrix (RM) were implemented by the Ministry of Health under the leadership of the National AIDS Control Council (NACC), NASCOP, the National Treasury and Ministry of Planning, and the Council of Governors in partnership with PEPFAR, UNAIDS, and GF. Additional participants and invitees included the Ministry of Devolution, United Nations Joint Team on HIV/AIDS (UNJT), World Bank, and other multilateral/bilateral donors, in-country experts and academia, civil society, private sector, and PEPFAR Kenya. The SID and RM's findings play an important role in the planning of COP20 investments, principally through improving approaches to 'sustainable' programs with the triangulation of SID 2019 with

Monitoring, Evaluation, and Reporting (MER) data, 2018 APR, FAST, and Table 6 outcomes. For the GOK, the SID and RM will serve to inform transition to greater domestic resource mobilization.

SID results showed some progress in Kenya toward sustained epidemic control. Two elements scored dark green but stakeholders still noted the need for an in-depth review with respect to further investments required in those areas (quality management and market openness). Four elements were light green noting progress toward sustainability, but still requiring catalytic investments mainly by the local host government (performance data, policies and governance, planning and coordination, and domestic resource mobilization). The remaining 9 elements were yellow (described below) and needed some degree of support. As with the previous SID 3.0, no elements scored red.

**Civil Society**: Mappings of HIV stakeholders and coordinating points have not been prioritized and Kenya National Bureau of Statistics (KNBS) has not been engaged for information on sources of coordination. There are not strong measures to prevent duplication and accountability by all stakeholders in HIV programming. Private sector healthcare providers are infrequently included in planning and monitoring activity tracking.

**Commodity Security and Supply Chain:** There has been minimal increase in the GOK allocation for procurement of HIV commodities over the last three years and minimal Ministry of Health financing for supply chain functions and operations other than staff salaries at national and county levels. No comprehensive supply chain assessment to determine status and inform priorities and investments has been conducted over the last three years.

**Private Sector Engagement:** Ministry of Health, together with development partners, are currently working on a private sector engagement framework that will guide PEPFARs private sector engagement. The framework will provide a national strategy to guide coordination and integration of existing public health structures with the private sector in order to improve overall quality of care and decongest the public facilities. National Health Insurance Fund (NHIF) should include a comprehensive HIV package for private health facilities.

In COP20, PEPFAR Kenya will embrace a client-centered approach through scaling up decentralization of drug distribution and working with private and public sectors to explore insurance cover for HIV care and subsidization of HIV drugs for patients receiving services at private facilities by choice.

Although the majority (about 95%) of PLHIV enrolled in HIV care and treatment receive services in the public sector or through FBOs, 2% of patients receive care from private sector providers while another 2% either receive care through donor-subsidized social

franchises or self-fund through private insurance and out-of-pocket payments. Currently, the private sector cannot access free donated HIV drugs for their patients.
At the end of Q1 2020, Kenya was providing HIV treatment to 1,137,111 patients of which close to 9,000 were receiving services from the private sector network. With a TX NET_NEW of only 59,194 clients through FY19 this translates to a net gain of approximately 4 for every 10 newly-identified clients, Kenya continues to struggle with retention of PLHIV within the treatment program.

Reasons why patients do not keep their health appointments or drop out of care altogether range from distance to hospital, other pressing commitments, or lack of transport. The distance that stable patients have to travel to pick up medication can be reduced by making drugs available within their community for pick up. Drugs can be dispensed by local pharmacies, private or public facilities, or other designated safe and privately-owned pick-up points. PEPFAR Kenya, through USAID, is leveraging Sustainable Financing Initiative funds to lay the groundwork for scaling up client-centered care and the decentralization of drug distribution. SFI funding is currently being used in three counties (Nairobi, Busia, and Kajiado counties) to determine the potential of private institutions as drug distribution sites and their ability to serve as pick-up points. The pilot project is also testing consumer interest across a range of indicators to better understand how and where to quickly start scaling up decentralized drug distribution in COP20.

**Epidemiological and Health Data:** The system for uniquely identifying patients is weak. Integration of service data with other administrative data is not adequate.

**Laboratory:** HIV rapid testing as well as complex lab testing – EID, VL and HIV drug resistance testing (DRT) - are mostly done by donor-supported staff. Although sufficient instruments are available, the supply chain and specimen transport system are mainly donor supported. HIV-related lab testing (HIV rapid testing, CD4, VL, GXP, CrAg, HIVDRT) financing is donor dependent.

**Service Delivery:** GOK provides minimal (1-9%) financing for KP services. KP services rely on substantial external support. There is limited continuous structural engagement with CSOs to inform service delivery and programing and minimal focus by both development partners and GOK in supporting fully functional, community-based service delivery.

**Human Resource for Health/Health Workforce**: For the last three SIDs, the HRH score has remained relatively unchanged. Domestic funding for health workforce interventions has not increased. Improvements are needed in health workforce management and monitoring, especially with respect to performance quality, supervision, and minimization of absenteeism. The community workforce is not recognized or well-resourced. Health workforce data systems are incomplete and not optimally utilized.

**Technical and Allocative Efficiency:** In spite of an increase in resource allocation, optimal utilization remains a concern. Areas of inefficiency are still to be determined and

mitigation measures have not been put in place. Further, the country has no system for gathering cost information on a routine and standardized basis to inform decisions on resource mobilization and allocation. Data capture to determine and reconcile allocations and expenditures are not routinely undertaken.

**Financial/Expenditure Data:** There is limited financing in the government for conducting sustained surveys and surveillance activity. Development of a multiyear strategy with partners is necessary and should include annual costed work plans with a clear road map leading to sustainability.

Noting the drastic drops in civil society and private sector engagement, the SID activity recommended that, to improve sustainability, NACC develop a strategy to improve the coordination and integration of the private sector with the existing public health structures in order to enhance overall quality of care and decongest the public health facilities. CSO coordination requires improvement to reach communities at the center of the HIV response. CSOs also need to be meaningfully engaged in accountability mechanisms beyond the Interagency Coordinating Committee (ICC) and GF Kenya Coordinating Mechanism (KCM).

**Transitions: County and Local Indigenous Partnerships**

As part of the expansion of partnership with counties to work on a strategic, joint, and coordinated HIV response, PEPFAR Kenya's Interagency Team will work with the Council of Governors' leadership (in particular, the Health and Finance Committee) to support county governments to strengthen systems for a sustainable HIV and health response in programmatic, technical, and fiscal spaces. These efforts will include additional coordination and collaboration with the U.S. Treasury and HRSA to provide technical assistance as part of a joint assessment leading toward a partnership agreement between PEPFAR, S/GAC, and counties, as well as detailed PEPFAR-specific implementing agency MOUs.

In addition, PEPFAR implementing agencies have made progress toward the global requirement of having 70% funding and implementation be directed to local indigenous organizations.

Under PEPFAR, a "local partner" may be an individual, a sole proprietorship, or an entity. However, to be considered a local partner, the applicant must submit supporting documentation demonstrating their organization meets at least one of the three criteria listed below.

a) an individual must be a citizen or lawfully admitted permanent resident of and have his/her principal place of business in the country served by the PEPFAR program with which the individual is or may become involved, and a sole proprietorship must be owned by such an individual; or
b) an entity (e.g., a corporation or partnership):

1. must be incorporated or legally organized under the laws of, and have its principal place of business in, the country served by the PEPFAR program with which the entity is or may become involved;
2. must be at 75% for FY 2020 beneficially owned by individuals who are citizens or lawfully admitted permanent residents of that same country, per sub-paragraph (2)(a);
3. at least 75% for FY 2020 of the entity's staff (senior, mid-level, support) must be citizens or lawfully admitted permanent residents of that same country, per subparagraph (2)(a), and at least 75% for FY 2020 of the entity's senior staff (i.e., managerial and professional personnel) must be citizens or lawfully admitted permanent residents of such country; and
4. where an entity has a Board of Directors, at least 51% of the members of the Board must also be citizens or lawfully admitted permanent residents of such country.

c) Partner government ministries (e.g., Ministry of Health), sub-units of government ministries, and parastatal organizations in the country served by the PEPFAR program are considered local partners. A parastatal organization is defined as a fully or partially government-owned or government-funded organization. Such enterprises may function through a board of directors, similar to private corporations. However, ultimate control over the organization rests with the government.

A summary of progress on the roll out of these efforts under COP19 and COP20 plans for county and local indigenous partner transitions are provided by each PEPFAR implementing agency below:

**USAID**

In Kenya, a key aspect of the journey to self-reliance is partnering with counties to strengthen local ownership and sustainability of results. Strengthening local institutions, promoting system change, and prioritizing long-term outcomes will be key. USAID will implement government-to-government agreements with counties that have demonstrated commitment to effective, inclusive, and accountable problem-solving and co-financing to achieve shared results.

In COP20, USAID Kenya is transitioning service delivery activities from international organizations to local partners through issuing 11 new awards. USAID will take a phased approach when implementing government-to-government funding. In COP20, USAID Kenya service delivery partners (SDPs) in Kakamega and Nakuru counties will sign fixed amount agreements (FAAs) with county governments, which will be designed to mirror fixed amount reimbursable agreements (FARAs) under government-to-government programming. USAID will ensure a public financial management risk assessment framework (PFMRAF), programmatic risk assessments at the national and county level, and Public Financial Management (PFM) funds flow reforms. These assessments will position USAID Kenya well to undertake government-to-government negotiations with

Nakuru, Kakamega, Busia, Kilifi, Turkana, and Mombasa in COP20, with anticipated awards in COP21 Q1.

**CDC**
The CDC Kenya program has a robust history of funding local partners. CDC is on track to move from 62% of its program funding allocated to local partners in COP19 to 70% in COP20. CDC Kenya has plans to increase its funding to local partners to above 70% in COP21 and is exploring procurement options for county government-to-government cooperative agreements in COP20.

**DOD**
DoD's move toward partnering with counties and transitioning responsibility and funding within PEPFAR has so far focused on HRH transition of GOK recognized cadres. This approach in COP19 has so far enabled transitions in 3 counties: Nandi (100%), Bomet (40%), and Kericho (~50% by April 2020). In addition, direct county funding has centered around ongoing discussions with Kericho and Nandi counties on models of funding.

For the Kenya Defense Forces, 95% of HIV-related health care providers are uniformed (up from 10% in 2004) and there has been an almost complete transition of lab commodities and opportunistic infection medications to KDF responsibility.

The next phase of transition at county level in COP20 will be building county capacity for program leadership through the Commodities and Clinical Technical Working Groups (TWGs). Additionally, DOD will support the transition to leadership by CHMTs and sub-CHMTs.

Direct county funding will be initiated through a phased approach, beginning with IP-to -county funding, in order to demonstrate a workable framework and accountability system. An MOU format is currently being developed in consultation with CDC and USAID that will facilitate future engagement and set commitments toward transition on both sides.

DoD's program transition to indigenous partners is being carried out through three defined approaches:

1. Reviewing the categorization of its IP and assessing its classification as a Kenyan organization.
2. Concentrating on ensuring that 100% of local IPs are indigenous organizations (this is currently the case and will continue into COP20).
3. Prioritizing sub-awards to Ministry of Health facilities and community organizations as much as the IM scopes of work allow.

**U.S. Treasury**
US Treasury will work with the PEPFAR Interagency Technical Teams on Costing, Sustainable Financing, Commodities, and Human Resources for Health to assess and quantify the current legal and fiscal investments by USG, as well as by GOK (including

Ministry of Health, National Treasury, and the counties) and other key donors. The outcome of this technical assistance will contribute to the areas of prioritization that will inform both the responsibility matrix and fiscal appropriations by the noted donors with the goal to move Kenya toward a fully-funded and locally-managed HIV program.

**Funding Solicitations**

Announcements for the solicitation of new implementing partners will be publicly published in FY20 and FY21 for CDC, STATE and USAID. The solicitations follow U.S. government procurements rules for an open and competitive process, and any organization will be able to apply, including local and civil society organizations, which can apply individually or in consortiums. The application process includes participation of any interested organizations in a pre-conference, that will be publicly announced. Due to the requirement to provide equal competition for all applicants, no organization or sub-population will be given un-equal advantage in the application.

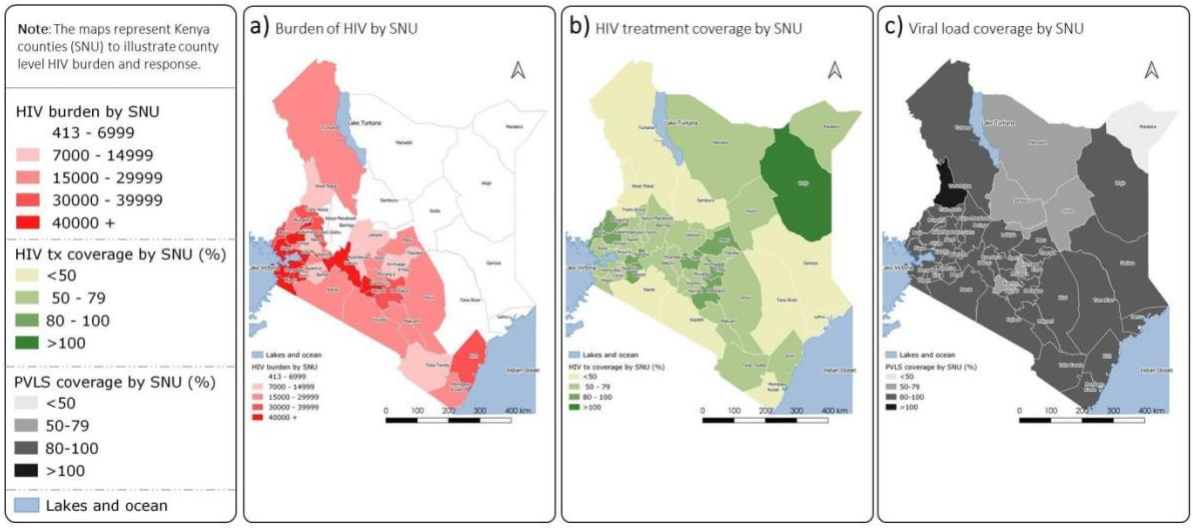
**2.5 Alignment of PEPFAR Investments Geographically to Disease Burden**

COP20 PEPFAR resource allocation was aligned to the county-specific needs for HIV epidemic control. Utilizing KENPHIA, Spectrum, and program data, resource needs were identified to close the county-level gaps in ART coverage and HIV incidence. In addition, resource needs to address population specific gaps such as HIV prevention among AGYW and KPS, as well as treatment gaps among children, adolescents, and young people were identified at county level.

Overall, 14 counties with high ART coverage (≥ 80%) but continued high HIV incidence – representing approximately 56% of new HIV infections - were allocated resources to maintain the large ART cohort, adopt a public health approach to HIV case identification, and enhance HIV prevention. Nine counties with ART coverage of 70%-79% were allocated resources to close the gap in identification through optimized testing while working to improve on retention. Seventeen counties with low ART coverage (<70%) contributing 25% of HIV burden but 45% of unmet need were allocated resources for intensified HIV case finding and improved linkage and retention on ART. Special consideration was made for counties with unique ART coverage and retention challenges such as the nomadic populations in Turkana, Narok, and Kajiado Counties.

As expected with program-based budgeting, strategic objective costs varied across implementing mechanisms due to different service delivery models between government, non-government, and private facilities with both higher costs in hard-to-reach areas and patient density in high-burden counties.

**Figure 2.5.1 % PLHIV by SNU, Total PLHIV by SNU, Coverage of Total PLHIV with ART, and Viral Load Coverage by SNU.**




Funding projections for meeting the COP20 targets were based on assessments of what partners actually spent in achieving similar targets in FY19 (Expenditure Analysis, 2019) and COP19 allocations. Reductions and increments, where applicable, were made based on proposed changes in approaches or projected efficiency savings.

## 2.6 Stakeholder Engagement

The COP20 process began with the release of the draft guidelines for stakeholder feedback in December 2019. This was followed by a series of pre-launch meetings with an initial breakfast meeting between the GOK and UNAIDS under the leadership of the Chief of Mission followed by a three-day consultation with the Council of Governors and county leadership from 45 counties, alongside national government representatives from the Ministry of Health, National Treasury, Department of Children, and the UNJT.

The PEPFAR Kenya interagency team officially launched the COP20 process with all stakeholders (including CSOs, FBOs, and the private sector) at the end of January which included the participation of the S/GAC leadership and respective Agency Headquarters Deputy Principles and Subject Matter Technical Leads. The launch was followed by a stakeholder retreat where progress on the current COP19 was shared, and strategic, programmatic, and technical data, policy gaps, and priorities were reviewed at national and county levels. Following the retreat, the PEPFAR team set up weekly bilateral meetings with the GOK which included the Ministry of Health, Treasury, and Council of Governors which ran concurrently with the consolidation and drafting of the initial Kenya COP20 proposal. The proposal was then presented to all key stakeholders for validation before the Kenya COP Delegation left for the Group 3 Johannesburg COP20 Regional Review Meeting in early March.

The delegation included Kenya PEPFAR Interagency Team Representatives led by the Chief of Mission Ambassador Kyle McCarter, the GOK team led by the Chair of the Council of Governors H.E. Wycliffe Oparanya, and Ministry of Health led by Drs. Nduku Kilonzo and Catherine Ngugi. The team also included CSO representatives from the National Empowerment Network of People Living with HIV/AIDS in Kenya (NEPHAK), KPs, FBOs, and AGYW. In addition, the team was also joined by GF, UNAIDs, and WHO leadership.

As part of the in-country consultations, the PEPFAR team has held joint meetings with FBOs, and stakeholders representing the following GOK-led TWGs: clinical, prevention, HIV and the law, strategic and health information systems, communication, KPs, and AGYW.

Alongside the GOK-focused meetings, the team continues to hold consultative meetings with CSOs as a consortium and key meetings with FBOs and KP communities, networks, and leadership. The PEPFAR interagency team will continue to host meetings during the quarterly POART and conduct ad hoc meetings with CSOs, private sector, UNAIDS and UNJT, GF, and GOK in order to disseminate program results and information, as well as obtain input on programs with specific considerations for human rights, gender, people with disabilities, KP, and PLHIV. It is critical that the COP20 process is closely linked to the finalization of the Kenya AIDS Strategic Framework II (KASF II), the conceptualization and proposal of Kenya's GF application, as well as the 2020/2021 Kenya budgeting processes. All written feedback and PowerPoint presentations from key stakeholders have been reviewed and incorporated into the final COP20 plan. In addition to addressing the detailed program issues and priorities raised in the COP20 SDS as part of the sustained dialogue with all stakeholders, the PEPFAR interagency team will maintain stakeholder engagement throughout the COP19 and COP20 implementation process. The team continues to engage all key external stakeholders - national and county government entities, UNJT, GF, CSOs, private sector, and professional bodies - throughout the program cycle.

### 2.7 Community Grants Initiative

The Community Grants Initiative will include a number of elements designed to ensure that patient-level experience is routinely considered in PEPFAR programming and within counties responsible for the HIV response. The main piece of the initiative is providing grants to community groups to monitor the HIV response both at the clinic and community level. Other key parts of the initiative include the establishment of a data collection system, the creation of fora to ensure action on results, and efforts to make data collection and use sustainable over time.

#### 2.7.1 Community-Led Monitoring

PEPFAR Kenya recognizes the critical role that civil society organizations (CSOs) play toward achieving epidemic control in Kenya. To this end, PEPFAR Kenya has supported CSOs in COP19 and COP20 to routinely collect patient- and provider-level data related to the quality of services provided at the site level in the three categories of counties (evolved,

scale-up, and reboot). The data collected will be an additional data stream used in conjunction with PEPFAR MER, Site Improvement through Monitoring System (SIMS), and GOK monitoring and evaluation data to help improve HIV/AIDS service delivery. Grants will be provided on a competitive basis for civil society groups in designated counties to monitor PEPFAR-supported facilities and activities.

A coordinating grant will be awarded as part of the initiative that will be responsible for developing metrics, ensuring continuity among grantees and providing targeted support to new grantees. Grantees in the respective counties will benefit from the expertise and experience of other stakeholders to provide support and enhance the capacity of the awardees for an objective outcome. The coordinating grant will be responsible for working with US Government PEPFAR staff as a single point of contact on general issues related to the monitoring of the initiative. The coordinating grant will also be responsible for providing community feedback on the operation of the county coordinating mechanism to PEPFAR staff and for following up any serious unresolved issues.

### 2.7.2 Establishment of a Sustainable Data Collection Platform and Recognition of Data

COP20 will support a web-based platform to aggregate and visualize patient and provider responses to questions using county government customer satisfaction surveys, SIMS, and the CSO Patient Satisfaction tool. This platform will provide users with real-time data on sites' quality of services derived from the responses. The framework will ensure data collected is in alignment with both the Kenya National Bureau of Statistics (KNBS) and United States Government. This will enable data collected under the community-led monitoring grant to be recognized as quality data in accordance with local government standards and be interoperable with other data sources. An additional component will include capacity building of CSOs to adhere to quality guidelines in their collection of citizen-generated data.

### 2.7.3 Support for a County Coordination Mechanism

The County Coordination Mechanism will be compromised of all key stakeholders within the county, including GOK, CMHT, NASCOP, PEPFAR Kenya, GF, CSOs, FBOs, and the private sector. The coordination mechanism will meet quarterly to review all relevant data sources (DQAs, SQAs, MER, SIMS, CSO CGI, etc.) with the aim to identify things that are working well that can be scaled and issues/barriers that need to be addressed, as well as evaluate adequate utilization of resources (both human and financial) within the county. The county coordination mechanism will not have authority over the community-led monitoring grants but will include the grantees in their meetings.

### 2.7.4 Routine Collection of Patient and Provider Feedback

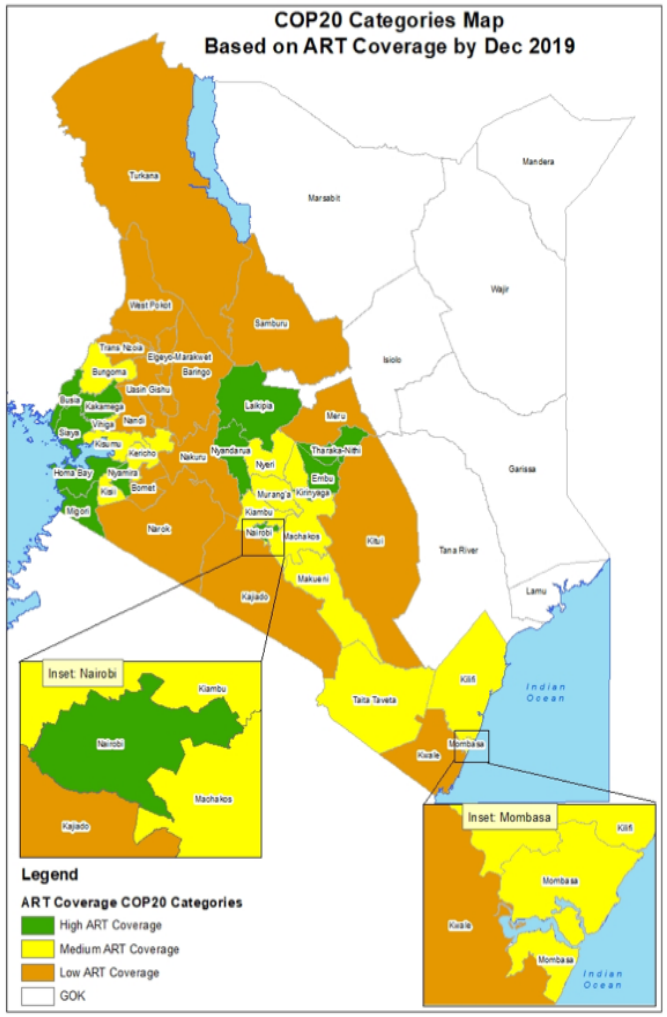
Through locally-based CSOs or individuals, COP20 will help establish a schedule to observe, collect, and scale survey questions related to service delivery from individual patients and clinical staff at both public and private facilities within a given county. These questions and observations will be centered around programmatic themes as determined

during the County Coordinating Mechanism meetings and entered into an anonymized data platform that will be available internally for decision making, as well as publicly. Grantees under the community-led monitoring initiative will be eligible for administering the survey questions.

# 3.0 Geographic and Population Prioritization

HIV prevention interventions and rapid ART acceleration will be tailored to each county's epidemiologic profile, as well as to age and sex disaggregated ART coverage and unmet need. Using updated 2019 HIV spectrum estimates and survey and program data, the 40 counties receiving direct PEPFAR support will be categorized into 3 clusters to guide the case finding approach based on ART coverage: high coverage (≥80%), medium coverage (70-79%), and low coverage <70% (Figure 3.0). For each county, specific interventions for ART scale-up will be driven by granular data on burden, coverage, unmet need, yield, linkage, and net ART growth. County-level analysis will also include a review of HIV incidence data to guide a scale up plan for high quality, effective HIV prevention interventions including PrEP, DREAMS, VMMC, and KP programs

**Figure 3.0: County Categorization Based on FY20 Q1 ART Coverage Using 2020 Spectrum Estimates and Programmatic Gaps**




| | High ART Coverage (11) | Medium ART Coverage (13) | Low ART Coverage (16) |
|---|---|---|---|
| **Survey Data** | 56% of all adult incident infections | 21% of unmet need | 45% of unmet need |
| **Case Identification** | High testing inefficiencies (at 35% of annual target) | Moderate testing inefficiencies (at 29% of annual target) | High testing inefficiencies (at 32% of annual target) |
| **Linkage and Retention** | Suboptimal proxy linkage and varying retention | Suboptimal proxy linkage and varying retention | Higher net loss of patients on treatment |
| **VL Suppression** | Low suppression among children | Low suppression among children | Low suppression among adults and children |
| **PMTCT** | Lower comparative MTCT rate | High MTCT rate | High MTCT rate |

Data Source: Spectrum 2020 Estimates PEPFAR Panorama 2/24/2020

1

**High Coverage**

There are fourteen counties with a high ART coverage of ≥80% (Nairobi, Homabay, Kisumu Migori, Siaya, Busia, Embu, Laikipia, Makueni, Kakamega, Kilifi, Kisumu, Tharaka Nithi, and Vihiga). Collectively, these counties contribute to 55% of national HIV burden, 32% of unmet ART need, 56% of adult incident infections, and 50% of new HIV infections among children. The goal of COP20 in these counties will be to achieve and sustain the 95-95-95 epidemic control targets.

In these counties, a public health approach will be adopted for HIV case finding. Targeted testing strategies emphasizing diagnosing those who are still unaware of their status with high yields are required. This includes, but is not limited to, the offer of index testing at qualifying facilities to identify sexual and biological contacts of newly-identified PLHIV and those who are not virally suppressed. Other appropriate public health approach testing strategies such as social network testing will also be implemented. In order to target interventions, full-scale implementation of recency testing will be used to define geographic "hot spots" and planned response to these hot spots, including case surveillance as appropriate.

At the health facility level, routine provider-initiated HIV testing and counseling (PITC) will be scaled down and interventions will shift instead toward diagnostic testing counseling to improve testing efficiency. A key focus will be the optimization of linkages and improved retention of the large cohort of ART patients by repurposing appropriate level of effort (LOE) among HIV testing counselors to support adherence counseling, retention, and viral suppression.

In order to address the continuing high incident of HIV infections in these counties, ART scale up will be complemented by implementation of HIV prevention interventions. Specifically, age-appropriate evidence-based layered prevention interventions targeting AGYW aged 9-24 years will be implemented through the DREAMS initiative. A key area of focus will be geographic and population saturation among the most vulnerable AGYW in Nairobi, Kisumu, Homabay, Siaya, and Migori Counties. These counties will also be prioritized for VMMC, with a focus on males aged ≥15 years. Owing to the age 15-29 years MC saturation in Busia County, VMMC services will be transitioned to GOK. KP in these counties will be targeted with a combination HIV prevention services and support for an optimized clinical cascade among those who are HIV infected. OVC in these counties will also be provided with services, prioritizing the most vulnerable, with a goal of ensuring 90% of C/ALHIV receive OVC services.

Continuing on from COP19, these counties will engage in a self-reliance process to transition support of HIV services to the GOK and the counties. HIV clinical services will be supported by one lead IP in the county, implementing an enhanced technical assistance model alongside continued right-sizing of HRH, with step-wise transition of mutually agreed activities to county government. Additionally, low volume sites identifying <10 HIV positive individuals and offering ART to <20 patients will be transitioned to GOK as

PEPFAR focuses direct support to large-volume, high-yielding sites. PEPFAR-supported direct service delivery HRH levels will remain constant overall but may be reallocated based on where the need is greatest, in addition to the overall reassignment of appropriate LOE of HIV testing services (HTS) counselors to support retention.

**Medium Coverage**

There are 9 counties with medium ART coverage. These range from 70-79% and account for 19% HIV burden, 21% of unmet ART need, 15% of adult incident infections, and 16% of new HIV-infections among children (Bungoma, Kiambu, Kirinyaga, Kisii, Kitui, Mombasa, Muranga, Nyandarua, and Nyeri). These counties will be supported to scale up index testing, targeted testing, and ART, in order to achieve >80% ART coverage.

Case identification will be done mainly through offering index testing at qualifying facilities to individuals newly diagnosed or with a recent non-suppressed VL test, efficient targeted facility testing, and self-testing for men and young people. Other appropriate public health approach testing methodologies will be implemented with the goal of offering testing to individuals unaware of their status and at high risk for HIV. In addition, enhanced support will be provided for adherence counseling, retention, and viral suppression. DREAMS program implementation will be enhanced in Kiambu and Mombasa, using an urban approach to ensure saturation of the most vulnerable locations and AGYW.

Similar to the high ART coverage counties, KPs will be targeted with combination HIV prevention services and support for an optimized clinical cascade among those who are HIV infected. The OVC program will prioritize the most vulnerable, with a goal of ensuring 90% of C/ALHIV receive OVC services.

HIV services in the medium ART coverage counties will be supported by one lead IP in the county, while low volume sites identifying <10 HIV positive individuals and offering ART to <20 patients will be transitioned to GOK. In order to achieve rapid ART scale up, partners working in these counties will be expected to meet their targets. Those not meeting targets will be placed on a corrective action plan that will include HRH re-alignment. HRH rationalization and right-sizing will be done to meet the workforce needs for these sites.

**Low Coverage**

There are 12 counties with low ART coverage of <70%. These counties contribute to 25% HIV burden but 45% of unmet ART need. They also account for 27% of adult incident HIV infections and 32% of new infections among children (Baringo, Bomet, Elgeyo Marakwet, Kajiado, Kericho, Kwale, Machakos, Meru, Nakuru, Nandi, Narok, Samburu, Taita-Taveta, Trans-Nzoia, Turkana, Uasin Gishu, and West Pokot).

Rapid ART scale up will be supported in these counties to increase ART coverage, with case finding focused on intensified yet optimized facility testing including implementing risk screening tools in sites not yet using them. Additionally, qualifying facilities will offer index testing to individuals newly diagnosed as positive and individuals with a recent non-

suppressed VP test result. Other appropriate public health approach testing methodologies will be implemented with the goal of offering testing to individuals unaware of their status and at high risk for HIV. Given the challenges posed by the highly-mobile nomadic populations in Kajiado, Narok, and Turkana counties, highly-targeted, population-based approaches will be implemented. The focus of treatment will be immediate linkage and optimized ART retention and viral suppression, aligned with livelihood activities such as food distribution. Turkana and Machakos counties will benefit from GF support for HIV prevention among AGYW. VMMC will also be implemented in Turkana and Nandi counties based on low MC coverage and high HIV burden. Owing to the age 15-29 years MC saturation in Nakuru County, VMMC services will be transitioned to GOK. KP in these counties will be prioritized for layered HIV prevention and an optimized clinical cascade for those who are HIV infected. Partner performance monitoring will be enhanced for rapid scale up of services. Additionally, a self-reliance sustainability process will be initiated, with the aim of commencing transition of HIV services to GOK and the counties.

Table 3.1 shows the current status of ART saturation and progress toward 95/95/95 across all SNUs as applicable.

**Table 3.1 Current Status of ART Saturation FY19-FY21**

| Prioritization Area | Total PLHIV/% of all PLHIV for COP20 | # Current on ART (FY19) | # of SNU COP19 (FY20) | # of SNU COP20 (FY21) |
|---|---|---|---|---|
| Attained | - | - | - | - |
| Scale-up Saturation | 782,764 (52%) | 649,369 | 699,029 | 18 |
| Scale-up Aggressive | 489,769 (32%) | 359,688 | 378,749 | 12 |
| Sustained | 224,099 (15%) | 122,973 | 133,195 | 10 |
| Central Support | 14,994 (1%) | 7,809 | - | 7 |

# 4.0 Program Support Necessary to Achieve Sustained Epidemic Control

### 4.1. Finding the Missing and Getting Them on Treatment

In COP20, PEPFAR Kenya will seek to close gaps in the 1st "95" for missing populations through county-specific tailored approaches. Case finding will shift toward a public health approach that will integrate disease surveillance and recency testing. At COP20's core, there will be increased engagement and collaboration with the Ministry of Health, both at national and sub-national unit (SNU) levels to enhance government-led case finding, monitoring, and response. Efficient and effective case identification strategies in COP20 will include implementation of index testing at scale with fidelity. Safety elements will be addressed and will involve intimate partner violence screening, adverse event monitoring, and reporting. Facilities and providers will be certified to conduct index testing.

Targeted risk-based testing will be conducted at health facilities, with social networking strategies (SNS) for adolescents and young people and scaled-up HIV self-testing. Additionally, recency testing will be rolled out to inform targeted response for both case identification and HIV prevention services. Real time monitoring through electronic data collection for HTS services (eHTS) will be scaled up. To ensure a targeted epidemic response strategy, a public health approach to disease surveillance will be integrated into HIV case finding.

COP20 will use a number of strategies to address safety concerns surrounding index testing as outlined below.

**Index Testing with Fidelity: Addressing Safety Concerns**

| Deliverables | PEPFAR Action Item |
|---|---|
| PEPFAR messaging to implementing partners will be devoid of a targeted % expectation from index testing.<br><br>Index testing services will be offered to all eligible clients at facilities that meet the certification requirement. | • PEPFAR Kenya will communicate to all IPs that there is no longer a specific target for index testing.<br>• IPs will immediately communicate to and remove any index testing-related targets that may have been in place at supported sites/facilities.<br>• IPs will immediately re-orient staff that index testing is voluntary and that clients can decline the service for any or no reason.<br>• IP work plans will not include targets for index testing. |

| | |
|---|---|
| PEPFAR IPs will collect and report routine data on the following index testing indicators:<br>1) # offered index testing<br>2) # who accepted index testing after counseling | • Although not reported in DATIM, facility index testing tools will be used to collect # of clients offered and accepted or declined index testing services. These data will be presented at quarterly review meetings with stakeholders<br>• PEPFAR will work with IPs to ensure proper documentation in the index testing registers in order to enable collection of acceptance and refusal rates per facility and IP. |
| PEPFAR IPs will monitor acceptance rates and offer technical assistance/QI where acceptance rates are higher than best practices suggest ensuring consent is meaningful. | • IPs will report on a monthly basis on the following indicators:<br>1) Total # of newly-diagnosed and virally-unsuppressed individuals offered index testing<br>2) Total # accepted and number of contacts solicited<br>• IPs will monitor acceptance rates versus safety concerns by facility and flag any site with safety concerns for immediate remedial action/steps.<br>• PEPFAR Kenya will follow-up with IPs on any additional mentorship and supervision with regards to the message that index testing is voluntary and also ensure that the 5 Cs outlined in the HTS policy guideline are observed at all times. |
| PEPFAR Kenya will carry out investment in proactive monitoring for adverse events and quality. | • PEPFAR IPs will use the REDCap Index Testing Minimum Program Components Tool to assess supported sites on index testing program gaps and training needs. This will not be considered as a certification tool, as it will only be used to assess quality of services. Data from the assessments will be shared with Ministry of Health and other stakeholders. Ministry of Health and other stakeholders may/will participate in the assessment process as part of the stakeholder/community monitoring processes.<br>• PEPFAR Kenya in collaboration with the Ministry of Health and other stakeholders will develop a multi-pronged, routine, continuous site monitoring plan covering:<br>▪ IPs role in site monitoring/QA including mentorship and supervision<br>▪ How to leverage/refine existing SIMS index testing monitoring questions to ensure they respond to safety monitoring aspects within index testing modalities/strategies<br>▪ County government and CHMTs' roles in quarterly monitoring of index testing programs |

| | |
|---|---|
| | ▪ How the community-led monitoring plan will be included in the quality monitoring plan/process for index testing programs.<br>▪ The schedule for routine monitoring by all multi-sectoral stakeholders. |
| PEPFAR Kenya will support a certification process that moves quickly, in which any facility that does not meet minimum requirements will be temporarily halted from conducting index testing until these requirements are met.<br><br><u>Note</u>: Facilities that implement index testing are expected to meet certification criteria; however, it is noted that not every PEPFAR-supported facility will implement index testing. | ● Participants during the certification process will include GOK, county governments, CSOs, Kenya Human Rights Watch, and other stakeholders<br>● Certification goals will entail the following:<br>▪ An index testing services' certification tool for the facilities/sites adapted by counties and stakeholders from the PEPFAR draft certification document<br>▪ Index testing certification for counselors, including a minimum of at least 1-year experience, aligned to GOK counselor certifications, and based on a stakeholder-adapted PEPFAR draft certification document<br>▪ Index testing certification for index testing supervision and mentorship |
| PEPFAR Kenya will share data on index testing cascades with GOK and other stakeholders as part of the monitoring system for all facilities moving forward. | ● PEPFAR Kenya will report aggregated index testing services data starting with high volume facilities (e.g. those identifying >20 HIV positive per month)<br>● Monthly reporting for each facility includes:<br>▪ Aggregated # of clients aged >15 years offered index testing services (aggregated both newly diagnosed, and clients virally suppressed)<br>▪ Aggregated # of clients aged >15 years accepting index testing services (aggregated both newly diagnosed, and clients virally suppressed)<br>▪ Of those clients aged >15 years accepting index testing services, number of contacts listed by ages <15 years and >15 years.<br>● If a facility reports <20 clients offered index testing services in that month, a blank facility report with the note "low numbers reported" will be submitted<br>● PEPFAR will itself continue to assess sites with low volumes of clients offered index testing services (<20 clients per month). This will enable a phased approach by stakeholders by strategically focusing on facilities that report significant finding.<br>● Quarterly reporting for each facility will entail the following variables aggregated for clients aged >15 years across the entire index testing cascade<br>▪ # of clients offered index testing services<br>▪ # of clients who accepted index testing services |

| | |
|---|---|
| | ▪ Of those accepted, # of contacts elicited by age disaggregation of ages <15 years and >15 years<br>▪ Of the contacts elicited by the above age groups, # contacted, # known positive, # eligible for testing, # newly-diagnosed HIV positive, # HIV negative, and # HIV positive linked to care. |

**Table 4.1.1 Case Finding Activities Based on Art Coverage Category: Evolve**

| ART Coverage | County | Subcategory | Strategic shift | Stopping | Scaling up |
|---|---|---|---|---|---|
| >80% | **Homabay<br>Kisumu<br>Siaya<br>Migori<br>Kakamega<br>Busia<br>Kilifi** | High PLHIV, High coverage | • Shift toward surveillance and a public health approach to case finding as counties achieve epidemic control<br>• Shift HRH LoE toward support of high linkage and retention services<br>• Shift toward HTS offered by mainstream health care workers and lab staff | • Routine out-patient department (OPD) testing<br>• Temporary halt of partner testing for KP awaiting certification . | **Index Testing and Recency:**<br>• FY20/21: Index testing to focus on mopping up testing of cumulative contacts/networks<br>• FY20: establish case-based surveillance and recency for public health approach to case finding<br>• FY21: main case finding strategy - public health approach.<br>**PITC:**<br>• Malnutrition, TB, STI<br>• OPD testing - symptom-based, diagnostic counselling and testing,, opt in self testing<br>**HEI:**<br>• Testing for HEI will be aligned to the national PMTCT guidelines.<br>**Pediatrics>2 years:**<br>• Use of screening algorithm<br>**PMTCT:**<br>• Case finding for PBFW will be enhanced through maternal retesting as per national guidelines.<br>**VMMC:**<br>• Risk-based, symptom-based for aged >15 years<br>**Target populations:**<br>• KP - social network testing |
| | **Makueni<br>Vihiga<br>Nyamira<br>Embu<br>Laikipia<br>Tharaka-Nithi** | Medium/Low PLHIV | • Close subpopulation coverage gaps and shift toward surveillance and public health approach to case finding as these counties achieve epidemic control<br>• Shift HRH LoE | • Routine OPD testing<br>• Temporary halt of partner testing for KP awaiting certification . | **Index testing:**<br>• FY20/21: intensified index testing and mop up testing of contacts/networks<br>• FY20: establish case-based surveillance and recency for public health approach to case finding<br>**PITC:**<br>• Malnutrition, TB, STI<br>• OPD testing - risk-based and symptom-based, DTC<br>• Men and young people: opt out self-testing<br>**HEI:**<br>• Testing for HEI will be aligned to the national PMTCT guidelines. |

| | | | | | |
|---|---|---|---|---|---|
| | | | toward support of high linkage retention services<br>• Shift toward HTS offered by mainstream health care workers and lab staff. | | **Pediatrics>2 years:**<br>• Use of screening algorithm<br>**PMTCT:**<br>• Case finding for PFBW will be enhanced through maternal retesting as per national guidelines.<br>**VMMC:**<br>• Risk-based, symptom-based for aged >15 years<br>**Target populations:**<br>• KP- social network testing, index testing |
| | **Nairobi** | Urban county with large mobile population | • Focus on subpopulation coverage gaps and sub-SNU hot spots<br>• Shift toward surveillance and public health approach to case finding as these counties achieve epidemic control<br>• Shift HRH LoE toward support of high linkage retention services<br>• Private sector engagement for case identification and referral to treatment | • Routine OPD testing<br>• Temporary halt of partner testing for KP awaiting certification. | **Index testing**:<br>• FY20/21: intensified index testing to optimize/mop up testing of contacts/networks<br>• FY20: establish case-based surveillance for public health approach to case finding<br>• FY21: main case finding strategy - public health approach<br>**PITC:**<br>• Malnutrition, TB, STI<br>• OPD testing - risk-based, symptom-based, opt out testing<br>**Self-Testing:**<br>• Facility and community distribution of HIV self-tests (HIVST)<br>• Private sector engagement to increase access for HIVST (subsidize prices, dispensers)<br>**HEI:**<br>• Case finding for PBFW will be enhanced through maternal retesting as per national guidelines.<br>**Pediatrics>2 years:**<br>• Use of screening algorithm<br>**PMTCT:**<br>• Case finding for PBFW will be enhanced through maternal retesting as per national guidelines<br>**VMMC**:<br>• Risk-based, symptom-based for aged >15 years<br>**Target populations:**<br>• KP - social network testing |

**Note:** All measures to ensure implementation of index testing with fidelity and safety considerations as guided in Table 4.1.2. above will be observed in all PEPFAR- supported facilities. PEPFAR agencies in collaboration with stakeholders will monitor and provide oversight toward ensuring safety measures within index testing programs are inculcated.

**Table 4.1.2 Case Finding Activities Based on Art Coverage Category: Scale**

| ART Coverage | County | Subcategory | Strategic shift | Stopping | Scaling up |
|---|---|---|---|---|---|
| 70-79% (Scale) | **Kiambu Kisii Bungoma** | HIV PLHIV, High coverage | • Accelerate case identification toward optimal ART coverage<br>• Shift HRH LoE toward support of high linkage retention services | •Non-targeted OPD testing<br>• Temporary halt of partner testing for KP awaiting certification | **Index testing:**<br>• FY20/21: intensified index testing to optimize index case testing (ICT) cascades<br>• FY21: establish case-based surveillance and recency for a public health approach to case finding<br>**PITC**:<br>• Malnutrition, TB, STI<br>• OPD testing: symptom-based, DTC<br>• Subpopulations with suboptimal coverage: risk-based, opt out testing<br>**Self-Testing:**<br>• Community- and facility-based HIVST distribution<br>**HEI:**<br>• Testing for HEI will be aligned to the national PMTCT guidelines.<br>**Pediatrics>2 years:**<br>• Use of screening algorithm<br>**PMTCT:**<br>• Case finding for PBFW will be enhanced through maternal retesting as per national guidelines.<br>**VMMC:**<br>• Risk-based, symptom-based for age >15 years<br>**Target populations:**<br>• KP - social network testing, index testing |

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|---|---|---|---|---|---|
| | **Kitui**<br>**Nyeri**<br>**Murang'a**<br>**Kirinyaga**<br>**Nyandarua** | Medium PLHIV, Medium coverage | • Bring efficiencies to current testing modalities to increase case identification toward optimal ART coverage<br>• Shift HRH LoE toward support of high linkage retention services | • Non-targeted OPD testing<br>• Temporary halt of partner testing for KP awaiting certification | **Index testing:**<br>• FY20/21: intensified index testing to optimize ICT cascades<br>• FY21: establish case-based surveillance and recency for a public health approach to case finding<br>**PITC:**<br>• Malnutrition, TB, STI<br>• OPD testing - risk-based and symptom-based, DTC<br>• Subpopulations with suboptimal coverage: opt out self-testing<br>**Self-Testing:**<br>• Community- and facility-based HIVST distribution.<br>**HEI**:<br>• Testing for HEI will be aligned to the national PMTCT guidelines.<br>**Pediatrics>2 years:**<br>• Use of screening algorithm<br>**PMTCT**:<br>• Case finding for PBFW will be enhanced through maternal retesting as per national guidelines.<br>**VMMC:**<br>• Risk-based, symptom-based for age >15 years<br>**Target populations:**<br>• KP - social network testing. |
| | **Mombasa** | Urban area | Bring efficiencies to current testing modalities to increase case identification | • Non-targeted OPD testing<br>• Temporary halt of partner testing for KP awaiting certification | **Index testing:**<br>• FY20/21: intensified index testing to optimize/mop up testing of contacts/networks<br>• FY20: establish case-based surveillance for public health approach to case finding<br>• FY21: main case finding strategy - public health approach<br>**PITC**:<br>• Malnutrition, TB, STI<br>• OPD testing - risk-based, symptom-based, opt out testing.<br>**Self-Testing:**<br>• Facility and community distribution of HIVST<br>• Private sector engagement to increase access for HIVST (subsidize prices, dispensers)<br>**HEI:**<br>• Testing for HEI will be aligned to the national PMTCT guidelines.<br>**Pediatrics>2 years:**<br>• Use of screening algorithm |

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| | | | | | **PMTCT**:<br>• Case finding for PBFW will be enhanced through maternal retesting as per national guidelines<br>**VMMC**:<br>• Risk-based, symptom-based for age >15 years<br>**Target populations:**<br>• KP - social network testing. |

**Note:** All measures to ensure implementation of index testing with fidelity and safety considerations as guided in table 4.1.2. above will be observed in all PEPFAR supported facilities. PEPFAR agencies in collaboration with stakeholders will monitor and provide oversight toward ensuring inculcation of safety measures within index testing programs.

**Table 4.1.3 Case Finding Activities Based on Art Coverage Category: Reboot**

| ART Coverage | County | Subcategory | Strategic shift | Stopping | Scaling up |
|---|---|---|---|---|---|
| <70% | Nakuru<br>Uasin Gishu<br>Machakos<br>Meru | High PLHIV, high coverage | • Reevaluate current testing strategies to align to aggressively accelerate case finding to scale up ART coverage.<br>• Review HRH requirements and right size for effective case identification . | • Temporary halt of partner testing for KP awaiting certification | **Index testing:**<br>• FY20/21: intensified index testing to optimize ICT cascades<br>• FY21:establish case-based surveillance and recency for public health approach to case finding<br>**PITC**:<br>• Malnutrition, TB, STI<br>• OPD testing: risk-based, symptom based, DTC testing<br>• Subpopulations with suboptimal testing - opt out self-testing<br>**Self-Testing:**<br>• Facility and community-based distribution of HIVST<br>**HEI**:<br>• Testing for HEI will be aligned to the national PMTCT guidelines.<br>**Pediatrics>2 years:**<br>• Use of screening algorithm<br>**PMTCT**:<br>• Case finding for PBFW will be enhanced through maternal retesting as per national guidelines.<br>**VMMC**<br>• Risk-based, symptom-based for aged >15 years<br>**Target populations**:<br>• KP - social network testing. |
| | Kajiado<br>Trans-Nzoia<br>Kericho<br>Narok<br>Nandi<br>Kwale<br>Bomet<br>Taita-Taveta | Medium PLHIV | • Re-evaluate current testing strategies to align to aggressively accelerate case finding to scale up ART coverage.<br>• Review HRH | • Temporary halt of partner testing for KP awaiting certification | **Index testing:**<br>• FY20/21: intensified index testing to optimize ICT cascades<br>• FY21:establish case-based surveillance and recency for public health approach to case finding<br>**PITC:**<br>• Malnutrition, TB, STI<br>• OPD testing: risk-based, symptom based- DTC testing<br>• Subpopulations with suboptimal testing: opt out self-testing<br>**Self-Testing:**<br>• Facility and community-based distribution of HIVST<br>**HEI**:<br>• Testing for HEI will be aligned to the national PMTCT guidelines.<br>**Pediatrics>2 years:** |

| | | | | | |
|---|---|---|---|---|---|
| | | | requirements and right size for effective case identification . | | • Use of screening algorithm<br>**PMTCT**:<br>• Case finding for PBFW will be enhanced through maternal retesting as per national guidelines<br>**VMMC**:<br>• Risk-based, symptom-based for aged >15 years<br>**Target populations:**<br>• KP - social network testing |
| | Baringo<br>Elgeyo-Marakwet<br>West Pokot<br>Samburu | Low PLHIV | • Re-evaluate current testing strategies to align to county gaps toward accelerating case finding to scale up ART coverage<br>• Consider targeted community testing to reach nomadic communities<br>• Review HRH requirement and right size for effective case identification . | • Temporary halt of partner testing for KP awaiting certification | **Index testing:**<br>• FY20/21: intensified index testing to optimize ICT cascades<br>• FY21: establish case-based surveillance and recency for public health approach to case finding<br>**PITC:**<br>• Malnutrition, TB, STI<br>• OPD testing: risk-based, symptom-based, DTC testing<br>• Subpopulations with suboptimal testing: opt out self-testing<br>**Self-Testing:**<br>• Facility and community-based distribution of HIVST<br>**HEI**:<br>• Testing for HEI will be aligned to the national PMTCT guidelines.<br>**Pediatrics>2 years:**<br>• Use of screening algorithm<br>**PMTCT**:<br>• Case finding for PBFW will be enhanced through maternal retesting as per national guidelines<br>**VMMC:**<br>• Risk-based, symptom-based for 15+ years<br>**Target populations:**<br>• KP - social network testing.<br>• Community based strategies - for specific populations e.g. nomadic |

| | | | | | |
|---|---|---|---|---|---|
| | Turkana | Large county, difficult terrain, low coverage | Re-evaluate current testing strategies to align to county gaps toward accelerating case finding to scale up ART coverage | • Temporary halt of partner testing for KP awaiting certification | **Index testing:**<br>• FY20/21: intensified index testing<br>• FY21: establish case-based surveillance for public health approach to case finding<br>**PITC:**<br>• Malnutrition, TB, STI<br>• In-patient testing and OPD testing - risk-based, symptom-based<br>• Men aged 25-35 years - opt out self-testing<br>**HEI**:<br>• Testing for HEI will be aligned to the national PMTCT guidelines.<br>**Pediatrics>2 years:**<br>• Use of screening algorithm<br>**PMTCT**:<br>• Case finding for PBFW will be enhanced through maternal retesting as per national guidelines<br>**VMMC**<br>• Risk-based, symptom-based for 15+ years<br>**Target populations:**<br>• KP - social network testing, index testing<br>• County-based strategies (for specific populations, e.g. nomadic)<br>• Targeted community testing in specific hot spots using mobile strategies.<br>• Using SNS to reach out to AYP |

**Note:** All measures to ensure implementation of index testing with fidelity and safety considerations as guided in table 4.1.2. above will be observed in all PEPFAR supported facilities. PEPFAR agencies in collaboration with stakeholders will monitor and provide oversight toward ensuring inculcation of safety measures within index testing programs.

**Table 4.1.4 Finding Men: Strategies by County ART Coverage**

| High ART Coverage Counties | Medium ART Coverage Counties | Low ART Coverage Counties |
|---|---|---|
| **Adult Men** | **Adult Men** | **Adult Men** |
| • HIV active case surveillance using a public health approach.<br>• Index case testing with robust emphasis on implementation through a voluntary-based approaches and systems.<br>• Social network testing.<br>• Symptom-based testing (DTC) including testing of patients with symptoms of STI and TB aiming to reduce testing volumes.<br>• HIV self-testing through utilization of community-based distribution channels and FBO initiatives to reach young men in communities.<br>• Recency testing and hot spot mapping to guide targeted case finding efforts.<br>• Scale up eHTS to improve data quality, reporting, utilization | • Appropriate messaging and demand creation for uptake of HTS among men.<br>• Index case testing with robust emphasis on implementation through voluntary-based approaches and systems.<br>• Social network testing.<br>• HIV self-testing through utilization of community-based distribution channels and FBO initiatives to reach young men in communities.<br>• Implementation of stringent integrated HTS eligibility/TB screening and age- and risk-driven testing for all eligible persons.<br>• Immediate linkage of >95% of all new positives though interventions like linkage officers, tracking registers, locator forms, call back systems, and retrospective tracking of unlinked clients as well as peer escort systems.<br>• Scale up eHTS to improve data utilization and reporting systems. | • Recency testing and hot spot mapping to guide targeted case finding efforts<br>• Appropriate messaging for demand creation for uptake of HIV testing services.<br>• Implementation of stringent integrated HTS eligibility/TB screening and age- and risk-driven testing to reduce testing volumes.<br>• Index case testing with robust emphasis on implementation through voluntary-based approaches and systems.<br>• Immediate linkage of >95% of all new positives.<br>• Testing of all women with unknown status at 1st ANC visit and subsequent visits for those opting out at 1st ANC visit.<br>• HIV self-testing through utilization of community-based distribution channels and FBO initiatives to reach young men in communities.<br>• Scale up eHTS to improve data utilization and reporting systems. |

### 4.2 Retaining Clients on Treatment and Ensuring Viral Suppression

In COP20, PEPFAR's focus is ensuring retention of all patients on treatment and fostering adherence to ART for optimal viral suppression in order to maintain the health of PLHIV and achieve epidemic control. PEPFAR Kenya and partners will fully implement retention-related Minimum Program Requirements (MPR) in all PEPFAR-supported sites as these have a known impact on retention. MPR include:

1) Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.
2) Rapid optimization of ART by offering Tenofovir/Lamivudine/Dolutegravir (TLD) to all PLHIV weighing >35kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing >20kg and phase out of all nevirapine–based regimens.
3) Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services such as ANC, TB, co-trimoxazole, cervical cancer, PrEP, and routine clinical services affecting access to HIV testing and treatment and prevention. Community-led monitoring activities will help assure informal user fees are eliminated.
4) Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve ART coverage of men and adolescents. MMD models of care should also be implemented for stable PBFW and children to ensure continuity of ART access, especially with COVID-19.

#### 4.2.1 Improving Retention and Suppression among the Newly-Initiated and At Risk

COP20 will put more emphasis on adequate treatment preparation and adherence sessions as a strategy to retain patients newly initiated on ART. The highest risk groups for poor retention are men aged <40 years and women aged <35 years. In particular, PEPFAR Kenya reported low proxy retention rates among females aged 15-24 years (70%), males aged 25-39 years (78%), and females aged 25-39 years (80%). Taking into consideration the factors contributing to poor retention in these groups, COP20 will support efforts toward scaling up age- and sex-appropriate retention and re-engagement strategies across all PEPFAR-supported sites to maximize impact.

COP20 will also continue to strengthen responsive client-centered differentiated service delivery models to address attrition. Subpopulations such as older working men, school-going children, and adolescents and young adults will benefit from flexible clinic operating hours and appropriate appointment spacing. PEPFAR Kenya is already supporting multi-month prescriptions and will continue to work with the Ministry of Health to fast track policy formulation allowing for up to six months dispensing of ART.

COP20 will support community ART groups to take HIV services closer to clients, ensuring that their life goes on as uninterrupted as possible. PEPFAR Kenya will ensure PEPFAR sites display and enforce policies on patients' rights, stigma, and discrimination and utilize community CSO groups to monitor implementation. The program will ensure regular and

systematic monitoring and follow-up of non-linkers, missed clinic appointments, and patients defaulting treatment using HTS registers, appointment registers, missed appointment lists, defaulter registers, and lost-to-follow up reports from EMRs. Partners will implement a system of appointment reminders with priority given to high risk/vulnerable groups such as Viremia clients, men, and younger cohorts. To promote accountability, sites will establish stakeholder engagement forums with appropriate representation from key subpopulations to provide input on service design, monitoring, and improvement.

In COP20, PEPFAR Kenya will put emphasis on a client-centered approach for traced clients whose treatment has been interrupted and are returned back to treatment. Coordinated facility and community strategies will ensure a consistent affirmative messaging that provides positive reinforcement for re-engagement while addressing underlying barriers to adherence and retention. The approach should be tailored to individual clients while rapidly linking traced defaulter clients to treatment sites.

PEPFAR Kenya will also work together with communities of PLHIV, young people, and KP to set up community level-support groups that allow PLHIV to be supported both at facility level, as well as at community level. This will be a continuation of COP19's commitment to work with communities to scale up retention.

**4.2.2 Improving Retention and Suppression Among Children**

COP20 will continue to support efforts to improve retention through scale up of best practices such as family-centered differentiated models of care for children. Stable parent-child pairs will benefit from multi-month refills, fast-track refills at the facility, as well as community refills together with their family members at community ART distribution points. Unstable pairs will receive frequent follow up, family-centered psychosocial support, home visits, linkage to OVC, and directly observed therapy (DOT) where applicable. PEPFAR Kenya team will work with the Ministry of Health toward policy change including MMD among children, with 3-month refill and 6 months spacing for CLHIV aged 5-10 years, family-friendly scheduling, and consideration given to selecting times and dates for school-going children. COP20 will support the establishment of formal relationships with OVC IPs to address the psychosocial and economic needs of children and high-risk adults who are caregivers and to utilize case management approaches, including linkage with OVC services.

COP20 will continue to support efforts at phasing out nevirapine-based regimens by the end of April 2020 and optimizing treatment among children and adolescents.

**4.4.3 Improving Retention and Suppression among Adolescents and Young People**

For adolescents and young people living with HIV, COP20 will scale up use of optimized DTG-containing regimens for all eligible clients. As with children, MMD and family-centered approaches for drug pick-ups will be implemented. Both healthcare workers and peer-led psychosocial groups will be utilized for treatment literacy and knowledge.

Learners will be supported at school to adhere to medication and provided disclosure support.

COP20 will continue to support community approaches to increase adolescent and young adult adherence through peer groups and treatment buddies. COP20 will use Operation Triple Zero champions to promote appointment keeping and adherence, as well as work with schools to decrease stigma, discrimination, and violence against ALHIVs. PEPFAR sites will be supported to continue provision of psychosocial support and education related to transition to adult HIV treatment using transition readiness assessments. Through community engagement forums, sites will meaningfully engage adolescents and young people and incorporate their feedback to further improve design and program implementation.

### 4.2.4 Improving Retention and Suppression Among Adults

In COP20, PEPFAR Kenya will continue to support ART optimization to ensure complete transition of all eligible PLHIV to DTG-based regimens as preferred first-line treatment including the newly-identified positives linked to treatment. In FY19, Kenya reported 495,623 patients (44% of all patients on treatment) on MMD. The program team will work closely with the Ministry of Health to adopt policy on 6-month MMD and fast track a drug refill model to ensure scale up of MMD to eligible PLHIV across all PEPFAR-supported sites.

The program will support provision of flexible or extended clinic hours for working clients and convenient community ART refill systems, including decentralized drug distribution in private community pharmacies. Male-friendly services - such as men-only clinic spaces and fast track waiting times for working men - will also be implemented. PEPFAR Kenya will enhance psychosocial support through scale-up of enrolment of newly-initiated PLHIVs to support groups.

PEPFAR Kenya will implement a patient tracking system including a tracking log or missed appointment register capturing information needed to track patients, methods, and timing of attempting contact, and outcomes of each attempt. Sites will continue to integrate SIMS into their CQI activities and triangulate SIMS data with MER to identify gaps for decision-making and program improvement.

### 4.2.5 Improving Retention and Suppression within PMTCT

In FY21, the PMTCT support will be restructured to focus on retention on ART, VL testing coverage, and viral suppression. The program will support development of client-centered high-risk categorization and management and improve ART cohort register documentation including reporting. Capacity strengthening for mentor mothers will be supported to provide structured peer-led support to improve adherence, retention, and viral suppression among HIV positive pregnant and breastfeeding women. Individual case management will be promoted. To address low VL testing coverage reported in COP19, the program will conduct a data audit from the ART cohort register to confirm documentation

and coverage followed by harmonization of the processes and measurements (VLC and VLS). Cohort data reporting will be extended beyond site level (county, IP, and national level). PBFW and development of PMTCT-specific Undetectable=Untransmissible (U=U) messaging in support of VL literacy.

### 4.3 Prevention, Specifically Detailing Programs for Priority Programming

#### 4.3.1 DREAMS: HIV Prevention and Risk Avoidance for AGYW and OVC

The goal of the DREAMS Kenya Program is to reduce new HIV infections and prevent and respond to violence among AGYW. In COP20, DREAMS will continue to prioritize implementation within the high burden counties, targeting 321,491 of the most vulnerable sub-population of AGYW (aged 9-24 years).

Characteristics of the most vulnerable AGYW include being out-of-school, orphanhood, inconsistent condom use, having more than one sexual partner in the last six months, having sex with older men or engaging in transactional sex/sex work, having an STI, being married early, and experiencing some form of violence. The program will continue to scale up implementation within the current DREAMS SNUs with the aim of attaining saturation in Kisumu, Siaya, Homabay, Migori, and Mombasa.

The core package of interventions in DREAMS works collectively to address HIV prevention at different levels. At the individual level, DREAMS empowers AGYW to reduce risk for HIV, unintended pregnancy, and violence. At family level, DREAMS carries out economic activities for families, supports positive and effective parenting, and targets sexual partners of AGYW with highly effective HIV interventions such as HTS, VMMC and ART. At community level, DREAMS works through interventions that educate AGYW and young men and mobilizes communities for norms change with the view of keeping girls HIV free and safe from violence.

As the impact of DREAMS continues to be observed within the DREAMS SNU's, the program will continue to address quality gaps and focus on educational subsidies and economic strengthening among the AGYWs aged 15-24 years, including working closely with partners to monitor program package completion across age bands in FY20 and FY21. As at end of December 2019, a total of 197,872 AGYW had completed the required DREAMS package of interventions with a coverage of vulnerable AGYW of only 26% and a ward coverage of 57%. The program will increase its geographic footprint in all the wards within the saturation counties (older DREAMS counties) while scaling up service completion rates for expanded DREAMS programming.

Achieving a layered core package of services for vulnerable AGYW and avoiding a piecemeal approach in implementation in various locations calls for well-coordinated activities, standard operations procedures (SOPs), joint planning, and tracking of layering at the individual AGYW level. The program will therefore strengthen DREAMS/OVC integration and coordination with county stakeholders and local partners to maximize use of the current platforms to reduce AGYW vulnerability and new HIV infections. To

effectively track service integration, the DREAMS database will be further developed to include utilization of unique identifiers for OVC (CPIMS unique identifier) supported in the DREAMS program. The database will also help track the target population of AGYW by age categories who are receiving the full core package of services, including the number of interventions received by beneficiaries to monitor overall partner progress toward achieving full layering.

#### 4.3.1.1 Primary Prevention Among 9-14-Year-Olds

The DREAMS Kenya program reached 116% of AGYW aged 9-14 years (58,372 out of 50,400 annual target) by APR 2019. The DREAMS program will continue to strengthen HIV and violence prevention in girls aged 9-14 years through age-appropriate interventions while enhancing layering to meet the multiple needs of the vulnerable girls, their families, and their communities. In COP20, the target for this subpopulation will increase to 54,447, targeting them with primary prevention interventions aimed at preventing any form of coercive, forced or non-consensual sex and preventing early sexual debut. These interventions will continue to incorporate skills that support healthy decisions, prevent violence, as well as monitor school retention. Additional interventions will target the communities and families surrounding these adolescents through small group interventions to increase communities' and caregivers' skills and knowledge to adequately support adolescents. The program will increase the proportion of female OVC at risk of contracting HIV receiving intensified HIV and violence prevention interventions in the DREAMS program within the DREAMS SNU's.

COP20 planning has utilized the VAC's survey report to generate post-violence care county-based targets. The program will therefore strengthen GOK prevention and response to violence by supporting communities and caregivers through awareness raising, sensitization, service delivery points, and referral protocols. In addition, the program will support health care workers through training and supporting gender-based violence (GBV) recovery centers located within the high burden counties to support GBV survivors, the majority of whom are adolescents. Through DREAMS, accelerated AGYW sensitization on GBV, demand for services will also be created.

#### 4.3.1.2 Quality Improvement and Layering

Provision of multiple evidence-based services from the DREAMS core package of services (primary, and additional secondary or contextual) to each beneficiary is a core principle of DREAMS programming. In COP20, the DREAMS program will intensify its efforts to actively link beneficiaries to actual services at safe spaces as initiated by the provider for biomedical interventions, as opposed to passive referrals to ensure that full layering takes place. Close monitoring of partners' performance will be prioritized to ensure that most of the services required are offered at the safe spaces as applicable, and in a timely manner. To achieve full layering, in COP20 the program will implement different approaches that include:

- Collapsing some of the modules in the financial capability intervention (financial literacy) without losing the core elements to reduce the time it takes to complete the intervention
- Baseline HTS and subsequent testing based on assessment for eligibility
- Developing a monitoring system that tracks multiple intervention delivery during small groups module-based sessions at the safe space level
- Enhancing DREAMS program linkage to health facilities for strengthened facility-community linkage and cross referral
- Working with mentors to create demand for services among AGYW with poor layering and analyzing the AGYW_PREV indicator at ward and safe space level on a regular basis to inform how to direct specific intervention implementation and reduce the risk of duplicative service provision.

The program will also encourage formation of CQI teams to help analyze specific challenges with service package achievement. This will inform review of delivery modes, strategies, and settings as applicable. In COP20, the program, together with relevant stakeholders, will target beneficiaries to responsibly transition AGYW aged > 25 years.

#### 4.3.1.3 Progress and Specific Plans for COP20

By APR 2019, PEPFAR program in Kenya achieved a 60% service completion rate with 177,585 AGYW completing primary package and required secondary intervention out of 257,020 active AGYWs in the program in 2019. In COP20, the program has increased the annual targets from 252,000 to 321,491 AGYW with a greater emphasis on saturating current DREAMS SNU's. The age group ratio has shifted from 20%:30%:28%:22% in COP19 to 20%:35%:30%:15% in COP20 for the age bands 9-14 years, 15-17 years, 18-19 years, and 20-24 years respectively. DREAMS plans to fast track implementation in the four original SNU's to increase the number of AGYW completing the primary package of services while attaining saturation in Kisumu, Siaya, Homabay, Migori, and Mombasa. Ward coverage in these counties will be guided by HIV case finding and population estimate of AGYW. In view of reduced HIV incidence in Kiambu and programmatic experiences in finding the most vulnerable girls, the program will target to achieve 50% saturation. In Nairobi, the urban model of implementation will be used to achieve a saturation of 60%.

Geographic expansion within the current SNU's will be achieved through transition of older AGYW who complete all required DREAMS package of interventions. These are exited from the program and newly-identified vulnerable AGYW are enrolled into the program. It is expected that there will be internal AGYW-based transitions and additional age-appropriate services will be layered as AGYW transition to the next age category.

Of the 321,491 AGYW to be reached in COP20, the distribution of AGYW targets by SNU was arrived at based on the following:

1. Calculation of total at risk (aged 10-14 years) and (aged 15-24 years) based on OGAC guidance on vulnerabilities
2. Calculation of expected population of AGYW to reach 75% target saturation
3. Already completed DREAMS package and coverage as at FY20 Q1

4. Gap analysis to reach 75% saturation
5. Estimated expected number of AGYW to fully layer/complete package of required interventions and total fully layered by FY20 Q4 to get the projected coverage at FY20 Q4
6. Gap to saturation (75% saturation) while adjusting the gap expected in Nairobi and Kiambu to get the new targets and projected coverage

Below is the COP20 target distribution by age and County

**Table 4.3.1: FY20 DREAMS Targets by SNU and Age Group**

| SNU | Distribution | 20% | 35% | 30% | 15% |
|---|---|---|---|---|---|
| | Total 9-24 | 9-14 | 15-17 | 18-19 | 20-24 |
| Homabay | 32,666 | 4,473 | 11,262 | 10,143 | 6,789 |
| Siaya | 10,164 | 4,715 | 2,581 | 2,603 | 266 |
| Kisumu | 22,779 | 4,479 | 7,966 | 6,846 | 3,487 |
| Nairobi | 112,172 | 18,743 | 39,043 | 34,087 | 20,299 |
| Kiambu | 44,742 | 6821 | 15,100 | 13,968 | 8,853 |
| Mombasa | 47,524 | 7,693 | 16,482 | 14,559 | 8,789 |
| Migori | 51,444 | 7,523 | 17,775 | 15,894 | 10,251 |
| **TOTAL** | **321,491** | **54,447** | **110,209** | **98,100** | **58,734** |

In COP20, PEPFAR Kenya will continue to improve DREAMS and OVC integration. PEPFAR Kenya will work collaboratively with OVC to reach additional girls aged 9-17 years enrolled in OVC who are at increased risk of HIV infection and violence in DREAMS SNUs. These AGYW will be provided with primary prevention of sexual violence and HIV interventions, which form part of the DREAMS package.

PEPFAR Kenya will reach 186,931 adolescent girls and boys with school and community-based HIV and violence prevention interventions. All the AGYW will be assessed for HIV testing and all individuals eligible will be offered a test. PEPFAR Kenya will:

- Aim to reach 80% coverage in HIV testing for those eligible for testing
- Initiate 14,000 AGYW ages 18-24 years on PrEP
- Provide condom education to 186,931 AGYW ages 15-24 years
- Offer post-violence care services to 16,075 AGYW
- Support 35,285 young women to gain vocational skills and access non-PEPFAR supported economic strengthening opportunities
- Reach 32,800 parents and caregivers of AGYW ages 9-17 years with parenting/caregiver programs
- Support 79,761 AGYW to remain in school or progress to secondary schools

#### 4.3.1.4 Social Asset Building

COP20 will reach 321,491 AGYW within the 7 DREAMS SNU's through an asset-based mentorship program. The program will strengthen safe space activities to improve service layering and monitor intervention completion. PEPFAR is currently promoting innovative ways of enhancing safe space participation among young women out of school aged 18-24 years to accommodate their child-care and economic responsibilities. The program will reduce frequency of safe space meetings to improve participation and retention. Priorities for COP20 DREAMS implementation will involve exiting older AGYW who are fully layered, while systematically identifying and engaging additional AGYW who are most vulnerable to HIV acquisition, improving the package of economic strengthening services offered to AGYW (including exploring potential job opportunities), accelerating PrEP uptake, and improving DREAMS coverage to achieve saturation in the old DREAMS SNU's. The program will also work closely with the PMTCT program to manage referral and linkage of pregnant AGYW age <24 years while ensuring that all the DREAMS beneficiaries complete the core package of relevant services.

#### 4.3.1.6 Reaching Male Sexual Partners of AGYW:

The program will continue to use the safe space platform to characterize male sexual partners of AGYW and work with other PEPFAR programs to reach male sexual partners with effective biomedical services such as HTS, condoms, VMMC, ART, and violence prevention. AGYW aged >18 years enrolled in DREAMS will be encouraged to discuss the referral services with their sexual partners, as well as facilitate referral for services to their partners.

#### 4.3.17 PrEP

DREAMS will continue to scale up PrEP among eligible AGYW aged 18-24 years, while a total of 267,044 AGYW aged 15-24 will be targeted with PrEP information, education, and communication. An estimated 14,261 AGYW aged 18-24 years will be newly initiated on PrEP. Key priorities will include community sensitization to reduce myths and misconceptions around PrEP and to increase demand among eligible AGYW.

#### 4.3.1.8 Combined Socio-Economic (CSE) Approaches

Achievement in CSE interventions has been low. COP20 will continue to work with implementing partners to support market-driven vocational training, linkage with private, national, and county government entities to secure employment and entrepreneurship opportunities for DREAMS beneficiaries. PEPFAR Kenya will explore potential job opportunities and tailor vocational training to such opportunities. A total of 216,877 AGYW will be taken through financial capability training, out of which 35,285 will be screened for readiness for business start-up, trained on entrepreneurship, and linked to financial and loan institutions, as well as other government grants such as the youth fund. Additionally, 44,114 will be supported through fee subsidies, transport, and baby minders to join TVET institutions for vocational training. Additional AGYW Ambassadors will be identified and linked to employment as mentors or trained as facilitators or data clerks in the DREAMS

program. PEPFAR Kenya will work closely with the DREAMS Ambassadors to identify AGYW for specific economic strengthening interventions as appropriate.

#### 4.3.1.9 Collaboration with Global Fund

PEPFAR programs will be aligned to the GF investments to expand coverage for DREAMS into Kisii County. The program will work closely with NACC and the GF recipient partner to discuss existing structures and opportunities to facilitate geographic expansion and saturation. The program will actively participate in national and county adolescent and youth technical working groups and related fora.

#### 4.3.1.10 Monitoring Strategy

In COP20, we will continue to work with UCSF Global Program to conduct routine interagency quarterly program review meetings with USG implementing partners and to participate in NACC-led AGYW program review forums and data sharing processes. At USG level, there will be intensified monitoring with greater emphasis on service package completion while identifying and providing technical support to underperforming partners.

#### 4.3.1.11 Summary:

1. Kenya will continue to implement DREAMS in 7 SNUS (Homabay, Siaya, Kisumu, Migori, Nairobi, Mombasa and Kiambu).
2. The program will reach 321,491 adolescent girls and young women ages 9-24 years with comprehensive biomedical, behavioral, social protection, and structural interventions based on the Kenya DREAMS package of interventions.
3. Key priorities include increasing coverage and layering of interventions among AGYW to reach saturation.
4. Keys interventions to be strengthened include socio-economic strengthening to create opportunities for AGYW employment in DREAMS and expanded access for vocational training.
5. PEPFAR will support GOK to strengthen violence prevention and response including sexual and gender-based violence medical and forensic management (e.g. training health care workers to support a comprehensive clinical package of post-violence care).
6. Expanding PrEP uptake by providing information and education to 267,044 AGYW to create demand for PrEP services

### 4.3.2 Children and PMTCT

#### 4.3.2.1 Children and Adolescents

In COP20, PEPFAR Kenya in collaboration with the Ministry of Health will implement the SURGE/LEAP strategies with heightened partner monitoring and support to increase the number of C/ALHIV identified and linked to care and treatment. Biological children of index clients - both male and female - will be tested as part of the ongoing index testing. Positive children will also be considered as index clients and their child-siblings and biological parents will be offered a test.

COP20 will support violence screening and identification before and after index testing services to avoid unintended violence for these index clients. Conventional case identification among children will use different strategies for sick and well children. For sick children, COP20 will continue to support testing of all children at high-yield entry points including pediatric inpatient wards, TB units, and malnutrition clinics. Guidelines on strict adherence to the 5Cs as entrenched on the HTS guideline of 2015 will be enforced. Within the outpatient department, children will be screened for eligibility for HIV testing using an age-appropriate, pediatric HIV testing screening tool. Those eligible will be offered an HIV test. Early identification and linkage to ART for HEI will be enhanced through optimized HEI screening, enhanced uptake of EID within 2 months of birth, and enhanced mother-infant pair follow-up through longitudinal cohort tracking.

Due to high MTCT rates observed during breastfeeding, COP20 will work closely with OVC partners to follow up breastfeeding women who are newly enrolled, unsuppressed, have a history of lost to follow-up, and AGYW as a priority at household level. PEPFAR Kenya will jointly develop a checklist to aid OVC case workers in understanding what to monitor (e.g. drug adherence, nutrition/optimal weight, EID monitoring, adherence to infant feeding guidelines, and immunization). COP20 will strengthen linkage to OVC programs for CLHIV. Children and adolescents who experience sexual violence will be offered a package of services including HIV prevention HTS, PEP, or linkage to care if identified as positive.

COP20 will support identification of HIV-infected adolescents through SNS, HIV self-testing, and peer-led approaches. Enhanced psychological/mental health support systems will be provided for adolescents who test HIV positive. Sexually active adolescents will be offered assisted partner notification services (aPNS). Peer networks such as those developed through Operation Triple Zero will be utilized to obtain index cases for social network testing. COP20 will support the use of HIV self-testing to identify adolescents and use peers to distribute the HIV self-test kits and link the positives back to facilities for confirmation.

In order to accommodate in-school adolescents, COP20 will also support facilities to provide flexible hours for HTS, including Saturday and school holidays for in-school youth. COP20 will support collaboration with PMTCT to identify pregnant and breastfeeding adolescents and link them to Operation Triple Zero in a way that caters to the pregnant adolescent. Recency testing data will be used to map transmission in hot spots to improve targeting of HTS. Adolescents on the OVC platform will be screened for risk using the girl roster tools and the HIV screening tool with appropriate linkages to HTS and partner testing.

Finally, through targeted messaging to caregivers and parents, PEPFAR Kenya will support demand creation for pediatric and adolescent HTS. COP20 supports utilization of social media platforms to reach out to adolescents with messages on HTS and use of faith-based platforms to promote messages on pediatric and adolescent HTS.

#### 4.3.2.2 PMTCT

PEPFAR Kenya will collaborate with the DREAMS program to enhance identification and referral of PBFW from the community to health facilities for services including PMTCT. Identification of incident HIV infections among PBFW will be enhanced through maternal retesting as per national guidelines and per referrals and linkage to PMTCT services. PrEP will be availed for AGYW and PBFW identified to be at increased risk of HIV acquisition and referrals and linkage for AGYW to OVC services will be strengthened. Pregnancy intention assessment and support including family planning services will be enhanced to reduce unmet need for family planning and early identification and referral of pregnant women for services. HEI screening at immunization clinics to identify HEI from women diagnosed HIV positive during ANC, as well as new HEIs from women who missed ANC or who tested HIV positive following a negative HIV test at ANC, will also continue to support early identification and infant diagnosis of HEI infants as per national guidelines. Those who test PCR positive shall be linked to treatment.

### 4.3.3 Key Populations

In COP20, PEPFAR will continue to address key programmatic gaps in the prevention and clinical cascade among KP to achieve HIV epidemic control leveraging the transformative health systems investments made in the FY20. In COP20, 95% of FSW, MSM, and PWID based on the NASCOP 2018 KP size estimates will be targeted in 24 counties. These are counties categorized as high and medium burden based on Spectrum HIV estimates 2020. In COP20, PEPFAR will continue to build strong partnerships with the Key Populations Consortium, other KP-led and competent CSOs including Trans* organizations to ensure the KP program is owned and managed by KP for accelerated epidemic control. Achieving sustained epidemic control will be predicated on achieving optimal coverage of both prevention and clinical cascades along the 95-95-95 cascade.

The COP20 KP program will focus on optimizing population coverage, and accounting for the full prevention and treatment cascade. PEPFAR together with GF targets to reach 95% of all KP subtypes in Kenya with HIV prevention interventions, identify and link to treatment 95% of the KP living with HIV, and ensure viral suppression amongst 95% of all KP on treatment. Through the leadership of the Ministry of Health, there was enhanced geographic and population rationalization between PEPFAR and GF KP programming to increase efficiencies. The KP program in COP19, with technical assistance from OGAC in consultation with the Ministry of Health, was redesigned with focus on optimizing coverage and improving program quality to achieve 95-95-95 by 2025.

In COP20, PEPFAR Kenya, in consultation with KP community groups, will support service providers in ensuring that KPs are offered options at sites where they feel comfortable to get treatment and prevention services. To do this, the KP program in COP20 shall expand its reach through partnering with the KP community in the delivery of services through outreach models and DICEs (e.g. KP-specific stand alone and integrated drop-in centers and safe spaces). PEPFAR Kenya shall employ community ART delivery models to address

physical and psychological barriers to uptake and retention of KPs living with HIV on ART. COP20 shall focus on capacity-building within KP-specific sites and DICEs to provide comprehensive HIV services including ART.

In COP20, PEPFAR will continue with HIV prevention and treatment programming for the TG population in Nairobi, Mombasa, and Kisumu Counties where a significant TG population was mapped in the KPSE 2018. COP20 will scale up the peer outreach model at KP hot spots and safe spaces and strengthen integrated public health facility approaches to ensure optimal reach and program sustainability. The program will scale up SNS to enhance hot spot-based outreach services, with a specific focus on reaching new and younger MSM, FSWs, PWID, and TG populations. Strategies to improve service uptake - including recruitment of new peer leaders, promotion of long-serving peer leaders into outreach workers and HIV prevention officers, health worker training to offer KP-friendly services, increased targeted outreaches, and use of social media - will be intensified.

The program will coordinate with KP communities to offer health care worker sensitization at KP select referral public health facilities to provide friendly and dignified integrated KP services. In addition, PEPFAR will support sensitization of county government health teams, community workers, and local administration including chiefs, police, and others to ensure a safe environment for KP programs. This will also include support for KP-led GBV/IPV prevention, documentation, and response, including GBV/IPV cases that do not require HTS. Differentiated care models for KP will be scaled up based on national guidelines. KP will be provided a core package of services that includes condom and lubricant promotion and distribution, targeted HTS based on risk, linkage and timely initiation on ART for those testing positive, TB screening and treatment, provision of PrEP and PEP for all eligible patients, screening and treatment for STIs, peer education and outreach services, risk reduction behavioral interventions, violence prevention and post violence care, and alcohol and substance abuse counseling including Undetectable=Untransmittable (U=U) messaging.

In COP19, the PEPFAR Kenya KP program was redesigned to focus on the 90-90-90 cascade with the aim of achieving epidemic control by 2025 for KP, 5 years earlier than the general population. In COP20, there will be intensified efforts to institutionalize innovations implemented for the 90-90-90 goal via funding from both COP19 and the Key Populations Investment Fund (KPIF) to achieve 95-95-95 by 2025.

In COP20, the KP program was redesigned to focus on KPLHIV identification, linkage to treatment, and treatment optimization ensuring viral load uptake tracking and viral suppression. The following innovative approaches, otherwise referred to as wrap around services, were proposed and are being implemented to increase access of KPLHIV to treatment services:

- **To increase identification: Social network testing** (SNS), **Risk Network Referral** (RNR) and **Expanded Peer Outreach Approach** (EPOA) were

recommended and are being implemented, targeting FSW and MSM subpopulations. These approaches **use a model of peers** for mobilization, identification and referral, to expand program reach. The goal of the approaches are to help reach new KP cohorts, and refer them for testing, including increasing outreaches at new hotspots.

- **Linkage to treatment:** Both **peer navigators** and **HTS providers** were recommended on equal strength and have been engaged to follow up KPLHIV to **enhance and optimize linkage**. Strategies for enhanced linkage include HIV-positive client longitudinal follow up, through peer-reach, reach at hotspots, phone calling or SMS text. Additionally, they support health facility navigation especially in public health facilities, and treatment literacy (especially by the peer navigators).
- **Treatment Optimization:** Safe space (DICE) treatment models, integrated public health facility and hotspot outreach service provision and drug refills were suggested and are implemented based on client preference. KPLHIV who prefer safe space are offered comprehensive treatment services with referral for TB services when not available on-site.
    - Both DICE and integrated public health facility service delivery models, **offer services that are enhanced for KP**, including capacity building and training of all their staff to offer KP friendly services that are non-judgmental and non-stigmatizing services to KPs visiting or on referral for services, provision of services tailored to the KP population, and inclusion of peers in service delivery.
    - KPs who prefer by choice to seek treatment in regular non-KP sites, are followed up, to ensure uptake of ART and viral suppression.
    - During the COVID period, MOH provided guidance to all partners to provide up to 3months multi-month ART dispensing for all PLHIV regardless of their age and viral load status to ensure continuity of services.
- **Viral load uptake and suppression:** The Kenya KP program uses an enhanced PLHIV tracker that was first used by the PEPFAR program and has been adopted as a national tool to track viral load due date, sample collection and results receipt, document PLHIVs on treatment and services received. This has helped ease tracking and reporting PLHIV accessing ART in other facilities, including tracking and documenting VL results, and client follow up and support to ensure optimal suppression.

To achieve the 1st 95, HIV testing will target newly-enrolled KP at outreaches at new hot spots, using an innovative sexual network testing strategy to increase case identification. Self-testing, including virtual network platforms for MSM communities, will be promoted.

For the 2nd 95, community ART initiation through integrated outreaches, same-day ART initiations, shift to TLD, and a case management approach will be scaled up. Retention will be enhanced through a robust appointment management system and defaulter tracking with regular reporting of net new clients on ART, current on ART, and net losses.

COP20's 3rd 95 strategy includes scale up of Undetectable=Untransmittable (U=U) messaging for KP and case management approaches both at facility and community level.

Tracking of KP viral suppression by typology in referral facilities will be strengthened to ensure optimal uptake of VL testing and interventions for viral suppression. Innovations such as Shikamana - which combines counseling by health providers with support from trained peers to improve adherence among gay and bisexual MSM living with HIV for viral suppression - will be implemented. TB screening among KPs living with HIV will be continuously tracked and all presumptive cases investigated. Clients found positive will be initiated on treatment. Clients who screen negative for TB will be initiated on IPT based on eligibility.

The KP program will continue to implement innovative strategies to improve reach and case identification among KP. These will include SNS, enhanced peer outreach approaches, and HIV oral self-testing targeting both KP and their sexual partners. Since KPs and their sex partners are at ongoing risk for HIV acquisition, the program will scale up PrEP screening and enrollment as per the national guidelines to reduce HIV acquisition.

To increase service uptake, more KP-led organizations will be strengthened and sub-granted to expand community-led KP service provision. DICEs will be supported including provision of ART at all eligible DICEs alongside scale up of innovative case identification and wrap-around comprehensive services. Differentiated care, including multi-month prescriptions, that enhances adherence and retention will be scaled up. A human rights-based approach will be adopted to ensure that all interventions address stigma and discrimination. Through meaningful involvement of KP living with HIV, COP20 will address leaks in the prevention and treatment cascade through improved linkage, adherence, and patient literacy. PWID medically-assisted therapy (MAT) services will be scaled up by adopting a mobile outreach model to increase access to high-risk injecting drug users unable to access the established static sites. PEPFAR will engage the Ministry of Health to provide staff to MAT clinics to increase enrollment and uptake of services.

To monitor progress, robust data monitoring through comprehensive monitoring and evaluation systems will be required to ensure that programs are up-to-date and can intervene through real time use of data for decision making. The program will continue to collaborate with the Ministry of Health through the NASCOP KP technical support unit and other key stakeholders including GF and UNAIDS to continuously improve quality and performance of the program.

The PEPFAR Kenya KP program has aligned KPIF investment to the COP20 geographic and accelerated case identification, treatment optimization, and high impact prevention interventions. In COP20, KPIF resources will also be aligned with the OGAC funding landscape expectation of 70% for local implementing partners (LIPs) including sub-granting to local KP-led organizations. In COP20, PEPFAR Kenya is targeting to reach 136,297 FSWs, 80,064 MSMs, 1,635 PWIDs (with 7,936 on MAT), and 1,641 TG with HIV prevention and treatment services in 24 HIV high and medium burden counties. As part of compliance with WHO guidance, the KP program has included people in prisons and enclosed settings to ensure that persons under incarceration receive optimal,

comprehensive HIV prevention and care services. In COP20, the program targets 64,800 people in prisons with comprehensive HIV prevention, treatment, and support services.

### 4.3.4 VMMC

Kenya's VMMC program is currently implemented in 10 counties, all of which are now approaching or past 80% MC coverage among males aged 15-29 years. Since 2017, the country has been working toward an ambitious annual target to achieve MC saturation in males aged 15-29 years while expanding services for boys aged 10-14 years and contracting service for males aged >15 years to match their declining service uptake due to saturation. Consequently, Kenya's excellent annual VMMC target achievement has been increasingly met from among boys aged <15 years for whom conventional surgical circumcision is now known to be associated with a higher risk of glans injuries and urethral fistula. In COP20, VMMC targets are therefore limited to males aged >15 years. Based on historical performance and the number of circumcisions needed to achieve saturation in the 15-29-year age band, the national VMMC target will further decline from 300,000 in COP18, through 200,000 in COP19 to 54,844 in COP20. Conventional surgical circumcision of boys aged 10-14 years will stop but may be considered later if the newly-introduced strategies for eliminating current safety concerns are fully in place. Glans injuries have virtually been eliminated in Kenya's VMMC program following full transition to dorsal slit method of surgical circumcision for all ages

In COP20, two VMMC focus counties that have reached 90% MC coverage in the 15-29-year age band (Nakuru and Busia) will be transitioned out of PEPFAR support for direct service delivery but will receive limited COP20 funding for technical support during transition. As such they are not assigned service delivery targets but will report results attributable to PEPFAR inputs.

Six counties with MC coverage below 90% (Turkana, Kisumu, Homabay, Siaya, Migori Nandi) will receive comprehensive PEPFAR funding. Lessons from a recently-concluded VMMC sustainability pilot funded by PEPFAR CDC will be applied in moving the entire program toward full Ministry of Health leadership and financing. Early infant male circumcision service outlets already established through PEPFAR support will all be transitioned to the Ministry of Health. Areas of emphasis for VMMC in COP20 will include client-centered demand creation and other innovations to increase VMMC uptake by older men, routine offer of VMMC to males aged >15 years who test HIV negative in HTS at clinical and community settings, using VMMC as a platform for providing other health services to males including tetanus toxoid (TT) vaccination, and identification plus management of genital malformations. Support for continued operations of VMMC centers of excellence at Jaramogi Oginga Odinga Teaching and Referral Hospital and Homabay County Referral Hospital will continue in COP20.

### 4.3.5 Gender-Based Violence

In COP20, PEPFAR Kenya will continue to address gender-based violence (GBV) and inequality across the HIV cascade. The program will address the following four priorities:

- Address intimate partner violence (IPV) in the context of PrEP, index testing, and care and treatment (routine and clinical enquiry)
- Provide post-violence clinical care services at HIV care and treatment sites
- Improve linkage between community-based HIV and GBV prevention interventions and clinical post-GBV care services
- Improve monitoring of GBV case identification, prevention, and response activities

All certified sites conducting HIV index testing will be supported by COP20 to conduct mandatory inquiry for IPV on all clients offered aPNS. Providers will be expected to duly complete aPNS registers indicating that enquiry into IPV has been done. Similarly, all PrEP sites including DREAMS and care and treatment sites will be expected to conduct inquiry into IPV at both ART initiation and at follow-up clinical visits. Subsequently, all sites will be required to offer first line support (LIVES).

Clinical sites will integrate HIV and GBV clinical services. They will offer the full minimum package of post-violence clinical care (as defined by the GEND_GBV MER indicator) and referrals for local GBV response services. The program will implement the GBV quality assurance tool and apply the SIMS standard at all sites to assess the quality of post-violence clinical care services.

The DREAMS, OVC, and FBO and CSO programs will sensitize frontline staff and train facilitators who will administer screening and enrollment as to how to ask about violence. Additionally, staff will be re-oriented on their response as well as on how to provide first-line support (LIVES) and how to immediately refer to clinical and/or non-clinical GBV response services. Referral cards and information that will assist survivors to access GBV response services will be made available through facilitators and program staff. Survivors who test negative will be linked to HIV and GBV prevention programs.

All implementing partners will be monitored on GBV case identification, prevention, and response on a monthly basis. MER and custom indicators that measure gender norms change activities will be integrated into IP work plans. Quarterly reporting will be required from all IPs. Planned site visits will take place that will prioritize the highest volume sites and poor performing sites. At clinical service delivery points, clinicians will be required to enquire about GBV during ART initiation and routine clinical care. Survivors will be supported and referred to GBV clinical care.

### 4.4 Additional Country-Specific Priorities Listed in the Planning Level Letter

This information is covered in Section 4.1-3 above

### 4.5 Commodities

Funding for commodities continues to be highly volatile, with the contribution to the overall budget by PEPFAR, GF, and GOK fluctuating significantly year-by-year. In FY20/21, PEPFAR will support 53% of Kenya's total HIV commodities budget, with GF covering 36% and GOK 11%. Projections of FY21 commodity requirements against available funding shows

a funding gap of less than 15%, however, the magnitude of the deficit, if any, is dependent on target achievement across the various program components. Going forward, PEPFAR Kenya will engage GF and GOK to put in place a tripartite agreement on share purchases, with the GOK committing to a larger share of commodities over time. Overall, in FY21, GOK will fully fund certain essential HIV commodities, such as co-trimoxazole, while also increasing its budget share for rapid test kits, CD4 reagents, medicines for opportunistic infections, and condoms. Furthermore, there remains a need for increased GOK contribution toward the procurement of ARVs.

In FY21, PEPFAR Kenya's funding and procurement of commodities will continue to closely align to strategies adopted by different program areas. For prevention, in alignment to the strategy for efficient testing, procurement of rapid test kits will be significantly reduced, while procurement of HIV self-test kits and recency kits will be increased to support case-finding. Moreover, to meet the ambitious target of getting 100,000 clients on PrEP, procurement of required commodities (Tenofovir/Emtricitabine, rapid test kits, and serum creatinine reagents) have been fully budgeted. For care and treatment, PEPFAR will prioritize procurement of adult 1st line ARVs, specifically TLD with GF and GOK funding most of the second line and pediatric formulations except for LPV/r pellets which are to be procured through PEPFAR. A final Kenya supply plan, with commodities and quantities to be procured by each funder, is expected to be finalized before August 2020. For TB/HIV, PEPFAR will support the introduction of short course TB preventive treatment through procurement of approximately 50,000 courses of 3HP (Isoniazid-Rifapentine). Procurement of TB diagnostic commodities, specifically TB LAM and cultures for drug sensitivity testing (DST) have also been factored into the budget.

COP20 funding for EID and VL monitoring has been computed based on the WHO monitoring algorithms. Engagement between PEPFAR and GOK on alignment of country guidance on EID and VL monitoring to WHO guidance has been positive. It is anticipated that the alignment will be affected before the beginning of COP20. The GOK through counterpart funding will mitigate against commodity stock out should the alignment not be forthcoming. PEPFAR is also closely monitoring the rapidly evolving strains on the global pharmaceutical and non-pharmaceutical supply chain that have resulted from the COVID-19 pandemic, which may impact timely availability of commodities.

Adult and pediatric optimization processes are on track and COP20 procurement of commodities will further support these initiatives. There are no planned procurements of NVP, NVP-based, Efavirenz and Efavirenz-based regimens including Tenofovir/ Lamivudine/Efavirenz (TLE). Only TLD will be procured in FY21 in line with the revised recommendations where TLD is the preferred first line regimen for all population groups including children weighing >35kg, adolescent girls and women of reproductive age. Moreover, procurements of TLD will be limited to the 90-count bottles to support scale-up of differentiated service delivery through multi-month prescriptions and MMD for stable patients. For pediatric patients, optimal formulations will be prioritized in the country's FY21 procurement plans. This will include Abacavir/Lamivudine (ABC/3TC) 120/60mg,

Dolutegravir (DTG) 50mg, and age/weight appropriate formulations of Lopinavir/Ritonavir (LPV/r) such as LPV/r 100/25mg tablets and LPV/r 40/10mg pellets.

In addition, PEPFAR will work with GOK and other stakeholders to support efforts toward modernizing and entrenching a client-centered supply chain to maximize product availability, quality, affordability as well as convenience to the client. This will also include exploring options for efficiently and effectively reaching patients on treatment through tailored channels appropriate to their needs and preferences such as community ART distribution or utilization of other convenient locations for medicine pickup (e.g. private pharmacies) to strengthen adherence and retention. This approach would also decongest public health facilities allowing more focused, individualized, and quality care to be provided at facility level by health care workers to the non-stable patients who will continue to receive care at these centers.

Building on the gains achieved through the transition and integration of reporting of all commodity data through the DHIS-2, support will be directed toward improving data quality and use for decision-making. This will include development of appropriate dashboards and support for interoperability between the DHIS-2 and other related systems such as Web ADT, EMRs, and the KEMSA ERP to enhance visibility, transparency, and accountability. Moreover, PEPFAR, together with NASCOP and county governments, will continue to strengthen the supply chain by building capacity for commodity management and commodity security across all levels as well as ensuring accountability through proactively monitoring and mitigating procurement and supply chain related risks. Other initiatives to be prioritized will be the utilization of private sector capabilities and infrastructure such as Third-Party Logistics (3PL) in improving efficiency in the last mile delivery of commodities.

### 4.6 Collaboration, Integration, and Monitoring

PEPFAR Kenya will work with the Ministry of Health, UN agencies, and CSOs to enhance efficiency and cost-effective case finding interventions that will be implemented within human-centered approaches. Engagement will be through the national HTS technical working groups to enable collaboration with stakeholders to review HTS policy guidelines and revise to align with WHO 2019 guidelines.

PEPFAR Kenya will collaborate with stakeholders to review the HTS eligibility criteria for all subpopulations to reduce over-testing and improve yield as well as ensure safety and adverse event monitoring and reporting within index testing services. PEPFAR Kenya will also, in collaboration with Ministry of Health, work toward a public health approach in case finding. PEPFAR Kenya will involve the Ministry of Health in its activities and strengthen collaborative site visits and mentorship activities including performance reviews at county level.

PEPFAR Kenya will continue to work with and strengthen county teams and monitor IP performance closely through SIMS and quarterly reviews with performance improvement

plans done for poorly performing partners to ensure that they achieve their COP19 targets. TWGs in each program area will include the county Ministry of Health in order to bring about synergy and improve efficiency. Facility and targeted community outreach strategies will be used to identify individuals living with HIV among KP and other targeted groups (children aged <15 years, youth, and men aged >25 years) through high yield HTS modalities, such as partner notification services and index client testing populations. Strict multisectoral safety and adverse event monitoring and reporting systems will be put in place.

To increase linkage to treatment to 95%, PEPFAR will support client escorts, the use of telephone and short text message reminders, and in-person follow-up by peer educators. Further, PEPFAR will actively engage KP, PP, local communities, and other stakeholders to address stigma and discrimination, harmful gender norms, and other barriers to accessing HIV care and services, including PrEP for which GOK has established guidelines targeting KP/PP. In addition, PEPFAR will routinely forecast site-specific commodity needs and work closely with Kenya Medical Supplies Authority (KEMSA) to ensure service delivery points (SDPs) receive uninterrupted supplies, e.g. rapid test kits, condoms, lubricants, and methadone.

In scale up counties, PEPFAR will support intensified demand creation, targeted HTS, linkage to treatment, provision of PrEP for all eligible most-at-risk individuals including discordant couples, post-exposure prophylaxis (PEP), and VMMC. Innovative approaches will include enhanced monitoring for better tracking and retention, implementation of PHDP, creation of PLHIV peer networks, convenient clinic working hours, and public health personnel sensitized to KP friendly service provision. PEPFAR Kenya will work with Ministry of Health, UN, and CSOs to enhance and improve outcomes of C/ALHIV. Through the pediatric and adolescent TWGs, PEPFAR will work with all stakeholders to review pediatric ART policy guidelines and revise to align with WHO 2018 guidelines.

COP20 will support review of the HTS eligibility criteria for children and adolescents to reduce over-testing and improve yield for these priority populations. In collaboration with the Ministry of Health and CSOs, COP20 will support universal testing of all children of PLHIV newly diagnosed or existing in care. Further, PEPFAR Kenya will work with the Ministry of Health to implement family-centered PAMA care for child-caregiver pairs in care to ensure a standard package to guide implementation, standard operating procedures (SOPs), and tools to track performance.

In COP20, PEPFAR will continue to intensify partner performance monitoring by conducting SURGE/LEAP visits in addition to SIMS. IPs with poor performance across key indicators will be put on a performance improvement plan, with intensified bi-weekly monitoring. Joint quarterly review meetings will be supported, with the objective of cross-learning, showcasing what's working and what's not working, and identifying what should be taken to scale. Review meetings will also help in identifying strengths, barriers, and areas for improvement, and come up with corrective action plans with clear roles,

responsibilities, and timelines. Partners will have revised work plans to ensure issues identified are addressed.

### 4.7 Targets by Population

**Table 4.7.1 ART Targets by Prioritization for Epidemic Control**

| Prioritization Area | Total PLHIV | Expected current on ART (APR FY20) | Additional patients required for 80% ART coverage | Target current on ART (APR FY21) *TX_CURR* | Newly initiated (APR FY21) *TX_NEW* | ART Coverage (APR 21) |
|---|---|---|---|---|---|---|
| Attained | - | - | - | - | - | - |
| Scale-Up Saturation | 782,764 | 699,029 | 72,818 | 761,880 | 78,398 | 97% |
| Scale-Up Aggressive | 489,769 | 378,749 | (13,066) | 415,952 | 45,692 | 85% |
| Sustained | 224,099 | 133,195 | (46,084) | 168,024 | 38,259 | 75% |
| Central Support | 14,994 | - | (11,995) | - | - | - |
| Commodities (if not included in previous categories) | - | - | - | - | - | - |
| **Total** | 1,511,626 | 1,210,973 | 1,672 | 1,345,856 | 162,349 | 89% |

**Table 4.7.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts**

| SNU | Target Populations | 2021 Population Size Estimate | Current Coverage -2019 | *VMMC_CIRC* (in FY21) | Expected Coverage (in FY21) |
|---|---|---|---|---|---|
| Military Kenya | 15-29 Years | N/A | N/A | 850 | N/A |
| Homabay | 15-29 Years | 163,856 | 75.60% | 8,210 | 82% |
| Kericho | 15-29 Years | 135,109 | >90% | 7,257 | >90% |
| Kisumu | 15-29 Years | 186,453 | 77.90% | 6,856 | 85% |
| Migori | 15-29 Years | 164,129 | 85.30% | 3,108 | 89% |
| Nairobi | 15-29 Years | 691,335 | >90% | 3,000 | >90% |
| Nandi | 15-29 Years | 125,482 | 89% | 8,794 | >90% |
| Siaya | 15-29 Years | 140,706 | 80.30% | 3,759 | 85% |
| Turkana | 15-29 Years | 161,193 | 76.30% | 13,070 | >80% |
| | **Total** | **1,768,263** | **<80%** | **54,904** | **>80%** |

**Table 4.7.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control**

| Target Populations | Population Size Estimate (SNUs) and disease burden | Coverage Goal (in FY21) | FY21 Target |
|---|---|---|---|

| | | | |
|---|---|---|---|
| FSWs | 143471 (excluding <18 years), 167,940 (All) | 95% | 136,297 |
| MSM | 84277 | 95% | 80,063 |
| PWID | 1721 (Kisumu and Kiambu only) | 95% | 1,635 |
| Fisher Folk | Unknown | | 123,065 |
| Military | Undisclosed | | 61,776 |
| People in Prison and other enclosed settings | Unknown | | 64,800 |
| AGYW (9-24 years) | 859,905 (AGYW at risk in 7 DREAMS SNUs) | 37% | 321,495 |
| **TOTAL** | | | 783, 512 |

**Table 4.7.4 Targets for OVC and Linkages to HIV Services**

| SNU | Estimated # of Orphans and Vulnerable Children | | Target # of active OVC (FY21Target) OVC_SERV | Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY21 Target) OVC* |
|---|---|---|---|---|
| | Children (0-17) | | | |
| County | Total orphans due to AIDS | All orphans | | |
| Nairobi | 8,804 | 100,931 | 161,435 | 160,067 |
| Kisumu | 35,871 | 77,564 | 88,253 | 87,253 |
| Homabay | 43,306 | 84,457 | 88,173 | 87,217 |
| Migori | 30,692 | 85,615 | 51,597 | 51,249 |
| Kiambu | 15,260 | 68,149 | 42,337 | 42,067 |
| Mombasa | 21,198 | 45,840 | 35,388 | 35,240 |
| Siaya | 29,679 | 69,110 | 35,013 | 34,647 |
| Kilifi | 23,477 | 78,585 | 32,785 | 32,351 |
| Nakuru | 36,094 | 86,106 | 25,999 | 25,655 |
| Busia | 12,589 | 45,270 | 21,712 | 21,426 |
| Kakamega | 18,968 | 90,755 | 19,903 | 19,641 |
| Kisii | 16,600 | 88,166 | 16,110 | 15,898 |
| Bungoma | 15,085 | 85,531 | 12,662 | 12,494 |
| Kericho | 16,836 | 41,127 | 11,319 | 11,169 |
| Uasin Gishu | 23,282 | 46,016 | 11,147 | 11,001 |
| Turkana | 16,425 | 40,799 | 9,239 | 9,117 |
| Trans-Nzoia | 18,363 | 44,788 | 7,880 | 7,776 |
| Machakos | 13,107 | 45,782 | 6,819 | 6,729 |
| Kajiado | 18,503 | 44,319 | 6,796 | 6,706 |
| Meru | 12,778 | 50,713 | 6,568 | 6,482 |
| Makueni | 10,106 | 35,487 | 5,275 | 5,205 |
| Kitui | 13,201 | 43,486 | 4,544 | 4,484 |
| Muranga | 6,906 | 32,005 | 4,531 | 4,471 |
| Vihiga | 6,242 | 27,437 | 3,736 | 3,686 |

| | | | | |
|---|---|---|---|---|
| Nyamira | 6,930 | 41,156 | 2,250 | 2,220 |
| Kwale | 13,698 | 47,307 | - | - |
| Lamu | 1,833 | 6,886 | - | - |
| Taita-Taveta | 4,828 | 14,657 | - | - |
| Tana River | 3,843 | 18,620 | - | - |
| Garissa | 2,666 | 29,306 | - | - |
| Mandera | 3,114 | 34,934 | - | - |
| Wajir | 2,654 | 29,873 | - | - |
| Embu | 4,554 | 18,778 | - | - |
| Marsabit | 3,299 | 17,586 | - | - |
| Isiolo | 2,157 | 9,748 | - | - |
| Tharaka-Nithi | 3,261 | 12,645 | - | - |
| Nyeri | 5,536 | 20,725 | - | - |
| Nyandarua | 4,911 | 22,426 | - | - |
| Kirinyaga | 3,756 | 16,404 | - | - |
| West Pokot | 8,817 | 31,536 | - | - |
| Narok | 20,321 | 56,490 | - | - |
| Nandi | 14,825 | 38,261 | - | - |
| Elgeyo-Marakwet | 6,611 | 20,307 | - | - |
| Laikipia | 7,357 | 20,766 | - | - |
| Bomet | 15,655 | 42,586 | - | - |
| Baringo | 9,853 | 31,165 | - | - |
| Samburu | 4,228 | 15,215 | - | - |
| **TOTAL** | **628,079** | **2,055,415** | **711,471** | **704,251** |

## Table 4.7.5: Planned numbers of CLHIV < 18 enrolled in the OVC program by SNU

| SNU | Burden | OVC COP20 Counties | COP19 TX-CURR<18 Target | CLHIV Enrolled in OVC COP18(APR) | 75% Expected CLHIV Enrolment by COP19 (APR) | 90% Expected CLHIV Enrolment by COP20 (APR) |
|---|---|---|---|---|---|---|
| Nairobi | High | Yes | 14,635 | 4,676 | 10,976 | 13,172 |
| Homa Bay | High | Yes | 12,684 | 6,121 | 9,513 | 11,416 |
| Kisumu | High | Yes | 12,805 | 4,605 | 9,604 | 11,525 |
| Siaya | High | Yes | 10,298 | 3,750 | 7,723 | 9,268 |
| Migori | High | Yes | 7,746 | 2,704 | 5,809 | 6,971 |
| Mombasa | High | Yes | 5,364 | 1,235 | 4,023 | 4,827 |
| Nakuru | High | Yes | 4,606 | 1,563 | 3,454 | 4,145 |
| Kakamega | High | Yes | 4,550 | 2,792 | 3,413 | 4,095 |
| Kiambu | High | Yes | 2,980 | 1,028 | 2,235 | 2,682 |
| Uasin Gishu | High | Yes | 3,047 | 1,011 | 2,286 | 2,743 |
| Kisii | High | Yes | 3,137 | 1,041 | 2,353 | 2,823 |
| Machakos | High | Yes | 3,049 | 1,351 | 2,287 | 2,744 |
| Busia | High | Yes | 3,687 | 1,733 | 2,765 | 3,318 |
| Bungoma | High | Yes | 2,700 | 1,154 | 2,025 | 2,430 |
| Kitui | High | Yes | 3,508 | 810 | 2,631 | 3,157 |
| Kilifi | High | Yes | 1,591 | 1,090 | 1,193 | 1,432 |
| Kajiado | High | Yes | 1,573 | 748 | 1,179 | 1,415 |
| Trans-Nzoia | High | Yes | 1,256 | 619 | 942 | 1,130 |
| Turkana | High | Yes | 758 | 646 | 569 | 682 |
| Muranga | High | Yes | 396 | 660 | 297 | 357 |
| Laikipia | Low | No | 1,670 | 121 | 1,252 | 1,503 |
| Tharaka Nithi | Low | No | 1,125 | 568 | 844 | 1,012 |
| Baringo | Low | No | 1,726 | 330 | 1,294 | 1,553 |
| Elgeyo-Marakwe | Low | No | 1,098 | 171 | 824 | 988 |
| West Pokot | Low | No | 1,044 | 192 | 783 | 940 |
| Samburu | Low | No | 759 | 33 | 570 | 683 |
| Meru | Medium | Yes | 2,752 | 552 | 2,064 | 2,476 |
| Nyeri | Medium | No | 2,149 | 662 | 1,611 | 1,934 |
| Makueni | Medium | Yes | 1,134 | 817 | 850 | 1,020 |
| Kericho | Medium | Yes | 604 | - | 453 | 544 |
| Kirinyaga | Medium | No | 691 | - | 622 | 622 |
| Nandi | Medium | No | 530 | 459 | 397 | 477 |
| Narok | Medium | No | 263 | 420 | 197 | 236 |
| Vihiga | Medium | Yes | 2,361 | 628 | 1,771 | 2,125 |
| Nyamira | Medium | Yes | 1,377 | 402 | 1,032 | 1,239 |
| Bomet | Medium | No | 2,480 | - | 1,860 | 2,232 |
| Kwale | Medium | No | 2,103 | 225 | 1,577 | 1,893 |
| Nyandarua | Medium | No | 1,426 | 434 | 1,069 | 1,283 |
| Embu | Medium | No | 1,470 | 438 | 1,103 | 1,323 |
| Isiolo | Transition | No | - | - | - | - |
| Marsabit | Transition | No | - | - | - | - |
| Taita Taveta | Medium | No | 1,957 | 135 | 1,467 | 1,761 |
| Lamu | Transition | No | - | - | - | - |
| Tana River | Transition | No | - | - | - | - |
| Garissa | Transition | No | - | - | - | - |
| Mandera | Transition | No | - | - | - | - |
| Wajir | Transition | No | - | - | - | - |
| | | | **129,087** | **45,924** | **96,919** | **116,178** |

**4.8. Cervical Cancer Program Plans**

The National Cancer Control Program (NCCP) faces a number of challenges with respect to cervical cancer (CxCa) screening and treatment, including a shortage of screening and treatment facilities (22% and 6% respectively), low demand due to stigma, low awareness, human resources shortages, inadequate supplies of commodities, poor information management, inadequate capacity for histopathological diagnosis, poor access to palliative services, and poor referrals and linkages to treatment (KHFA, 2018)

Implementation of CxCa screening among HIV positive women is implemented in comprehensive care centers (CCCs) through support from the Ministry of Health. PEPFAR funding has not been used to fund screening since 2014 thus there is scanty implementation and reporting in some of the counties and at national level. CxCA_SCRN, CxCA_SCRN_POS, and CxCa_TX was introduced in the MER 2.3 (FY18) as reportable indicators. Reporting has been poor with PANORAMA data for FY19 showing a screening rate of 11%.

COP20 will work with the Ministry of Health and other stakeholders to address these challenges and improve screening among women aged 25-49 years living with HIV. COP20's priorities at site level will be to:

- Ensure cervical cancer screening for all HIV positive women aged 25-49 years
- Map facilities with cryotherapy, thermocoagulation, and LEEP equipment and develop referral mechanisms from lower-level facilities
- Ensure all screening sites have access to treatment services either onsite or through prompt referral per the Test and Treat approach
- Strengthen county-level histopathological laboratory investigation capabilities
- Support procurement of laboratory commodities for VIA screening
- Develop MPR for QA at screening and treatment sites
- Support health worker training and mentorship for CxCa screening and treatment
- Support county-level mentorship teams to mentor facilities on a regular basis and link to a county-level HIV TWG to improve screening QA
- Develop a county-level consultation mechanism for facility providers

COP20 will also strengthen demand creation at site level through use of IECs, health talks, and use of peers. As most facilities conduct CxCa screening in MCH clinics, COP20 will work to ensure seamless linkages between the CCC and MCH clinic, as well as same day intervention for those screened positive.

Additionally, COP20 will work to improve CxCA reporting at facility level though printing, development, and distribution of CxCa registers and reporting tools (including referral forms and summary tools). It will also support facilities in monthly monitoring and reporting of CxCa performance, as well as screened positive rates, treatment rates, and time to referral/treatment for those screened positive. To improve quality, COP20 will support facilities to develop client feedback mechanisms, such as suggestion boxes and questionnaires.

For women with advanced CxCa, COP20 will support linkages to palliative care services. Visual inspection of the cervix with acetic acid (VIA) will be supported as the primary screening modality. There are some sites piloting HPV screening and, in these sites, the HPV screening algorithm will be used.

At above site level, PEPFAR Kenya will support:

- Development of demand creation messaging and IECs
- National-level reporting through DHIS-2
- Regional cancer registries to improve population-level cervical cancer monitoring
- The National Oncology Reference Laboratory (NORL) to strengthen QA by providing mentorship to Level 5 and 6 facilities on histopathologic investigations
- Integration of cervical cancer screening and treatment into Kenya EMR
- NCCP for supervision and guideline development and implementation
- Optimal and quality reporting through both DATIM and DHIS-2

### 4.9 Viral Load and Early Infant Diagnosis Optimization

In COP20, priorities will be targeted toward the optimization of existing conventional and point-of-care (POC) systems geared toward efficiencies and strategic placements. These will include mapping out existing/active POC sites for both EID and VL, determining the capacity of existing sites, and monitoring POC utilization. Through lab-clinical interfaces, sites with high numbers of PBFW that will benefit from POC placement vis-a-vis conventional testing systems and available infrastructure will be prioritized for POC placement. COP20 will strengthen integration and optimization of sample referral networks to improve access and efficiency for VL/EID and the re-mapping and integration of sample referral networks. Currently, there are 67 POCs dedicated to VL and EID that are underutilized or frequently stocked out. In COP19, only 0.5% of all VL tests and 14% of EID tests were performed at POCs. In the lab optimization activities of COP20, PEPFAR Kenya will work with other stakeholders toward increasing efficiencies in equipment placement and utilization. This process will work toward adding value to sustainability purposes in the transition to domestic financing.

# 5.0 Program Support Necessary to Achieve Sustained Epidemic Control

In order to strengthen health systems in Kenya to achieve and sustain epidemic control, COP20 has prioritized systems-level investments based on gaps identified through various tools including progress made from SID 3.0 to SID 4.0 and the Responsibility Matrix (RM), quarterly POART/MER results, and SIMS using a consultative process with the Ministry of Health, CHMTs, the GF prime recipients, and CSOs and FBOs. During COP20 development, there was also extensive stakeholder engagement and consultation with the Ministry of Health, the National Treasury, county governments, GF, the Bill & Melinda Gates Foundation and other donors, as well as the private sector and UNJT.

Unlike previous years, where PEPFAR support was complementary to already available support for critical areas such as policy and governance, institutional capacity building, and harmonization of different information systems, this year the GOK and its development partners will build upon PEPFAR's resource commitments. More responsibilities with respect to systems support - including for commodities – are being transitioned to Ministry of Health at national and county levels to improve sustainability.

PEPFAR Kenya has reviewed progress made based on COP19 Table 6 areas to identify which areas are 'on' or 'not on' course to achieve intended outcomes and which activities are no longer relevant. Table 6 activities that require further investment to achieve and sustain elimination are included in COP20 Table 6 and linked to respective program areas. Activities related to systems support for transition and sustainability that are not in COP19 Table 6, but that are relevant to ensuring fidelity, have also been included.

As described in SDS section 2.4, SID domains scoring yellow (4.67-6.67: emerging sustainability) and requiring some investments are prioritized in COP19 Table 6 (including commodity security and supply chain (5.18), private sector engagement (5.71), epidemiological and health data (6.0), laboratory service (6.11), service delivery (6.33), and HRH (6.43). The SID elements of quality management (9.05), policy and governance (7.19), and domestic resource mobilization (7.18) appear to be sustained but still require ongoing investment based on the evolution toward UHC and the need for effective capacity for a devolved health system.

The following areas have been identified as requiring particular program support toward achieving and sustaining epidemic control:

### 5.1 Guidelines on Emerging Evidence

Program support is required to ensure a review of policies and technical area guidelines based on emerging evidence (e.g. revised HTC algorithms based on current HIV prevalence, emphasis on PLHIV retention through individual tracking and unique identifiers, new TB preventive therapy, and multi-dose scripting/MDD, etc.).

### 5.2 County Systems Strengthening

Key program strategic objectives for county systems strengthening include increasing sustainable finance and domestic resource mobilization for the health sector, improving the quality of training and increasing the number of those graduating and entering the workforce, improving management and leadership of the health workforce at the county level, and strengthening technical leadership and coordination for commodity management.

### 5.3 HRH

It is also essential to support functionality of the HRH units in counties where PEPFAR Kenya supports health services to ensure a rationalized and right-sized workforce that is efficiently utilized for HIV services at community and facility levels. Functional county HRH units have been effective in enabling county governments to prepare strategic plans and budgets to mobilize resources. Coordination of county and intercounty cluster fora will be supported to ensure that deeper engagement of counties and learning and adaptation of success in HIV management takes place. The PEPFAR-supported HRH data system will be used to guide decisions and budgets for a rationalized and right-sized workforce based on epidemic control needs. Workforce unrest and labor disputes have made it necessary to support regular engagements between the Ministry of Health, Council of Governors, CHMTs, and health worker leadership for a closer and continuous dialogue to minimize disruptions in PLHIV service delivery and target achievement and sustainability for epidemic control. County readiness assessments will be supported, and the findings used to identify HRH game changers that, when supported, will contribute to county maturity toward self-reliance and sustainable transition of investments. At the county and site level, it has been identified in COP19 that loss to follow-up is a major impediment to retaining those identified in care. As a result, IPs will be required to ensure there are health workers hired and supported to actively trace and bring back to care those lost to follow-up through community-level engagements and home visits among other innovative approaches.

### 5.4 Commodity Management

Strengthening technical leadership and coordination for sustainable commodity management at both the national and county levels will involve reinforcing commodity security TWGs, mainstreaming laboratory and nutrition commodities into one coordinated national supply chain system for all HIV commodities, in-service and pre-service curriculum development for supply chain management, and support for quantification and supply planning at national level.

### 5.5 Health Financing

Health financing approaches will include advocacy for increased allocations to health and HIV in the national budget, technical assistance in 7 counties to institutionalize county health planning and budgeting, and support for evidence generation to inform domestic resource mobilization including monitoring domestic resource mobilization trends.

COP20 will also support private sector engagements to facilitate access to affordable HIV/AIDS services in the private sector and reduce the financial and operational burden on the public health facilities, as well improve access to affordable HIV care and treatment services through private sector care, and technical assistance to inform NHIF reforms and related sustainable financing for HIV as part of GOK's UHC agenda.

### 5.6 Laboratory

Kenya has made substantial progress in optimizing diagnostic networks for VL and EID. COP20 activities will prioritize enhanced access to VL and EID testing services and timely return of results to support eMTCT and efficient follow-up of non-virally suppressed PLHIV for effective management. Maintenance of quality laboratory management systems (QMS) for national referral labs' VL/EID, TB, HIV-DRT and BSL3 labs will remain a priority activity to assure reliable, accurate, and timely VL/EID/TB/HIV DR results.

As per the COP20 guidance, planning level letter, and Kenya Ministry of Health strategy, PEPFAR Kenya will provide technical assistance toward the transitioning of VL/EID testing laboratories to the Ministry of Health-owned regional laboratories. Close monitoring of this process will ensure that the already high VL coverage and equipment (VL/EID, TB) optimization are not negatively impacted. In the process, gaps in effective and efficient identification of POC sites against conventional platforms will be addressed through the national VL TWG.

The national equipment calibration center will continue ensuring that the national and regional referral network hubs have calibrated pipettes, centrifuges, fridges, and freezers to optimize transition of dried blood spot (DBS) to plasma for increased accuracy in VL measurements to ultimately realize the goal of Undetectable = Untransmittable (U=U).

In an effort to ensure the quality of HIV/TB-related testing, PEPFAR will continue to support integrated external quality assessment (EQA) for HIV/TB diagnostics including for GeneXpert Ultra, TB LAM, RHT, VL and EID. The National Public Health Laboratory (NPHL) will be supported to coordinate Rapid Test Continuous Quality Improvement (RTCQI) activities including the creation of a national certification system for sites and testing personnel involved in rapid HIV testing. A national HIV recency testing QA program will be conducted under the framework of the HIV recency surveillance in Kenya. To foster sustainability of lab quality services for reliable results, technical assistance will be provided to the national lab diagnostic unit to coordinate national laboratory assessments and monitoring of Stepwise Laboratory Improvement Process Toward Accreditation (SLIPTA) implementation, ensuring harmony across stakeholders (e.g. World Bank, Ministry of Health, and the private sector).

PEPFAR Kenya will provide technical assistance toward establishing a national GTC waste management system for waste emanating from Roche VL/EID and GeneXpert cartridges. This will include mapping of incinerators with required capacity (>1000$^{o}$C incinerators) -

e.g. cement manufacturers - and development of a national Guanidinium thiocyanate (GTC) waste disposal network.

### 5.7 Strategic Information

As all PEPFAR Kenya-supported counties will be expected to implement key surveillance activities such as case-based surveillance, recency testing for all newly-diagnosed positives, and mortality surveillance, the health information system (HIS) is foundational to the ability to survey and monitor the epidemic and inform prompt program response for the achievement and sustainability of epidemic control. COP20 support involves the development of scalable, flexible, and context-appropriate HIS processes to facilitate client-centered services, program monitoring and reporting, and HIV disease surveillance informing public health strategies to achieve and sustain HIV epidemic control in Kenya.

COP20 will continue to support strategic information initiatives in all PEPFAR-supported counties so counties can generate and use high quality individual-level data to drive impact and move toward full ownership for sustainability. All county typologies will be supported to conduct continuous DQA and improvement initiatives strengthening timely, correct, and consistent reporting to the Ministry of Health through the DHIS-2 and PEPFAR DATIM systems in order to move toward data alignment and sustainability of information systems.

As Kenya moves toward a full public health response model at both county and national levels, it is expected that all facilities with a large number of people in HIV care will adopt and consistently use digitized health information systems. To promote flexibility in the developed systems and ownership of electronic medical records (EMR) by counties, COP20 will support the scaling and migration of all existing HIV EMRs to one open source digital health solution for the HIV sector, as guided by PEPFAR partnership with Ministry of Health under NASCOP direction.

Interoperability between HIS products will continue to be a priority to ensure that data fragmentation between siloed systems is reduced. Interoperability will allow for other HIS products and health-sector wide strategic information initiatives to build on PEPFAR Kenya's ongoing success with digital health solutions and enable the focus of PEPFAR's support on HIV/TB systems components. These HIS products include mobile health applications which play a pivotal role in meeting the dynamic and evolving program and data needs of the PEPFAR Kenya-supported HIV response, such as the need for early identification of non-virally suppressed patients, categorization of "stable patients," and timely detection of missed appointments. Other key systems include eHTS electronic HTS reporting and case-based surveillance.

# 6.0 USG Operations and Staffing Plan to Achieve Stated Goals

**6.1 USAID**

PEPFAR-Kenya is committed to epidemic control, moving swiftly toward a county-led model with indigenous partners assuming a greater role in direct service delivery, monitoring, supportive supervision, mentorship and technical assistance to maintain quality HIV service delivery. In COP20, communities through community-led monitoring will provide further oversight to all HIV services provided by USAID. To this effect, USAID will in COP20 (although beginning COP19), embrace county and community input in program planning as well monitoring to foster a stronger partnership around HIV/TB and social, client-centered service delivery.

The broad footprint in COP20 takes into consideration having adequate staffing to effectively engage other bilateral partners and national, county, and community stakeholders in co-creation, implementation and monitoring of programs. This is reflected in the COP19 interagency staffing patterns and level of effort (LOE) by program area and administration support.

The PEPFAR interagency discussed emerging and vacant positions to determine relevance for each agency, as well as the entire country portfolio, given the dramatic shifts in COP19 and moving into COP20. As such, USAID had 28 new positions. The number (full-time equivalents) of PEPFAR Kenya staff and percent of time allocated remain aligned to the interventions described herein and maintain coverage for SIMS, business processes, and intraagency partner management. USAID understands that moving to local partners and taking a county approach to service delivery will require intensive partner monitoring, as well as some capacity building, as USAID cements partnership with country governments and their development partners. County-by-county programing, planning, and monitoring, while geared toward laying a stronger foundation for local ownership, also comes at a higher initial cost of creating, building, and nurturing partnerships. This will require more human resources investment.

USAID Kenya has made an attempt to fill most of the long-term vacant positions and is working diligently to fill the remaining ones, some of which are under the process of being posted. All agencies reviewed vacant positions and updated those position descriptions to facilitate their re-advertisement in order to both meet the needs of COP19 while moving into COP20. This includes agencies utilizing standardized job descriptions and other pre-classified position descriptions to expedite the placement and hiring of new staff. However, the biggest challenge in filling positions is the approval process timeline which often creates lengthy delays up to 12 - 15 months. USAID has repurposed some of its local hire positions to improve oversight of program and fiscal management of PEPFAR partners. Some of these positions are going under classification in preparation for final U.S. Embassy Human Resources (HR) approval to be advertised.

Costs of doing business (CODB) is increasing slightly for USAID in COP20 due to: 1) a 5% increase from COP19 for internationally-recruited staff to cover for the staff salary and step increases during FY20; 2) a 6% increase from COP19 for locally-recruited staff to cover the staff salary and step increases implemented in FY20. There is also an inflation-driven increase for capital security cost sharing: computers, IT services, ICASS, management meetings, professional development, and non-ICASS.

USAID will, by the end of COP19, close most of its international mechanisms. New solicitations seeking local and indigenous partners are about to go out. By the end of COP19/beginning of COP20, USAID should have 70% of its funding flowing through local partners. With a significant increase in PEPFAR Kenya resources being provided directly to local entities, USAID/Kenya also must provide greater accountability for USG resources through fiduciary monitoring.

Additional oversight is required to manage the significant challenges of the Kenya context regarding corruption and fraud both within and outside of the public sector. A more labor-intensive approach is also required for increased oversight and management of USAID Kenya contractors and grantees to ensure that programs operate more efficiently and cost-effectively and that they meet PEPFAR targets efficiently and effectively. A critical component of this approach is more frequent monitoring, reporting, and analyzing of results to make course adjustments and adapt program approaches. USAID Kenya has also been unable to fulfill its SIMS requirements, which significantly increase the demand for USG staff time dedicated to field visits. Hiring additional staff will provide USAID support for a robust and intensive monitoring plan to achieve over 90% of its SIMS targets in COP19 and 20.

In COP20, USAID will continue with hiring new positions approved in COP19 to support local partner transition. There will no new positions in COP20. An increase in USAID staff dedicated to PEPFAR will also bring USAID into balance with other PEPFAR implementing agencies in Kenya. The USAID Kenya business model also is changing to one of more direct staff engagement in managing development relationships with local governments and counties. In COP20, USAID (through OVC, DREAMS, MNCH, and malaria) will work in about 34 of the 40 PEPFAR counties including 23 where they are the lead agency with HIV service delivery. This direct engagement with the GOK is aimed at strengthening and building the capacity of public institutions and building partnerships to leverage resources.

The 28 positions above the COP19 planning level include 16 public health specialist positions that will serve in partner management roles and spend approximately 60% of their time outside of the U.S. Embassy on monitoring and supportive supervision visits to local partners and local governments, particularly county governments. The additional staffing will lead administration, finance, and operational support activities along with partner management and will spend approximately 40% of their time monitoring activities in the field. USAID's vision is to increase in-house USAID staff capacity to reduce reliance

on international partner staff and transition to local partners. This will also enable USAID to make more effective use of U.S. taxpayer resources, as USAID will no longer have to pay international partners' overhead rates for "indirect costs."

With existing staff levels, both corruption and management capacity are significant potential risks as USAID expands its engagement with local partners as part of the Journey to Self-Reliance. Poor internal control is widespread in Kenya, and the hundreds of millions of U.S. taxpayer funds in commodities and other resources that are made available by USAID represent a ripe target for those who would seek to enrich themselves at the expense of Kenyans needing treatment and prevention services. Awarding a greater number of mechanisms to local organizations will increase the management and operational requirements of the mission. Current USAID staffing is inadequate to effectively and safely perform priority Mission goals and objectives.

Of the 5 long-term vacant positions reported in COP19, 3 have been filled. Those not filled have been reviewed and job descriptions updated to meet the evolving needs of the office. Of the 6 positions in process last year, 3 are filled. With the evolving needs of the office, and in preparation to engage in partnership building with counties and manage local partners, additional recruitment will occur next year to increase oversight around the supply chain and implement private sector engagement activities as well as orient all the new local partners in county programing.

**6.2 CDC**

CDC Kenya has decreased its staffing by 1 full-time equivalent (FTE) from COP19 to COP20. The position is administrative. CDC has a total of 14 FTE vacancies and intend to hire the majority of positions by the beginning of COP20. CDC is not requesting any new positions and intends to conduct a staffing review and ensure existing positions align to support county activities and readiness toward direct county government-to-government funding through CDC Cooperative Agreements as well as through enhanced site-level technical assistance. As such, CDC CODB remains similar to COP19 with anticipated increases in salaries and rent.

The CDC Kenya program has a robust history of funding local partners. CDC is on track to move from 62% of its program funding allocated to local partners in COP19 to 70% in COP20. CDC Kenya has plans to increase its funding to local partners to above 70% in COP21 and beyond and is exploring procurement options for county government-to-government cooperative agreements in COP20.

**6.3 Peace Corps**

As Peace Corps is reopening its program in Kenya and will have a small group of volunteers in 2019-20 (building to approximately 100 by 2022), it has requested the hiring of a locally-employed staff (LES) HIV Specialist via a Peace Corps personal services contract (PSC) mechanism. The incumbent will coordinate PEPFAR programming, monitoring, and reporting in Kenya, and coordinate the training of additional appropriately-funded staff,

trainees, volunteers, and Kenyan counterparts. These volunteers and their counterparts will be working in GOK health facilities, secondary schools, and CBOs or FBOs. The HIV specialist will ensure that training and programming funded by PEPFAR will be appropriately designed and implemented according to O/GAC guidelines. Additionally, they will coordinate the collection of data and submission of sub-annual program reporting (SAPR) and annual program reporting (APR) and the Peace Corps Kenya submissions of various planning tools.

**6.4 State**

In COP20, PEPFAR State will be hiring a DREAMS Coordinator to provide additional support to the country team with the expansion of DREAMS programming to new geographical areas as per guidance in the planning level letter.

**6.5 Department of Defense**

The positions that have been filled since COP19, as well as those still under recruitment, have been prioritized to best match the program priorities and reflect the interagency analysis on new positions. Each position has been aligned according to staffing, management, and operations that exist in COP19 and are still applicable for COP20.

Each position is designed to balance business process coverage, intra-agency partner management, and the technical needs associated with program implementation.
Depending on the role, staff will provide overall oversight to the SIMS. Those positions more focused on programmatic delivery will participate in SIMS assessments of DoD PEPFAR-supported facilities while providing technical assistance and guidance, interagency coordination, and communication.

Working with the DoD PEPFAR team, each staff member will be tasked with focusing on the support and improvement of the provision of technical assistance and oversight of linkage, retention, and client-centered services. In addition, identified staff will be tasked with providing technical assistance and oversight for the rapid roll out of small grants for community-led monitoring.

The USG DoD PEPFAR team is structured to deliver current PEPFAR activities, as well as those defined in the COP20 plan, and to continue to match the program requirements as more elements of the program are transitioned to county government.

The DoD in-depth approval process has led to some long-term vacant positions. Once through agency approval, the review of position description and classification process has been completed at Embassy management team level. Top priority positions have been filled and the recruitment process for other positions is ongoing.

All new positions have been designed to improve oversight of program and fiscal management of PEPFAR USG government-related functions while executing overall program oversight. Each position requires leadership and management experience that

extends beyond the capacity of the existing positions and, hence, requires a new hire rather than repurposing an existing position. Only one position is to be filled by a US citizen. Over the next 5 years, the roles and responsibilities of this position will evolve to include both PEPFAR and non-PEPFAR activities.

Increased workload, responsibility, and oversight requirements for the agency have increased over the last 10 years. DoD is currently lacking USG representation in the particular technical areas covered by the Deputy Director, Health Management Information Systems Specialist, and HIV Prevention Specialist. These DoD positions are required for technical representation and execution of PEPFAR-related government functions while providing oversight to ensure accountability, efficiency, and impact in the PEPFAR program.

DoD does not propose any major changes to the cost of doing business in COP20.

**Table 6.5: DoD CODB Staffing Recruitment Summary Table**

| Position | Role | International/LES | Recruitment Status | Reasons for delay |
|---|---|---|---|---|
| Director | Technical Leadership/Management | International | Pending | Lengthy agency approval process |
| Laboratory Director | Technical Leadership/Management | LES | Recruited, in position | |
| HIV Specialist, Care & Treatment | Technical and Programmatic Oversight and Support | LES | Pending | Slow agency process in classification and approval |
| Health Management Information Systems Specialist | Technical and Programmatic Oversight and Support | LES | Pending | Slow agency process in classification and approval |
| HIV Prevention Specialist | Technical and Programmatic Oversight and Support | LES | Pending | Slow agency process in classification and approval |
| Deputy Director | Technical and Programmatic Oversight and Support | LES | Recruited, start date confirmed | |
| TB Coordinator | Technical and Programmatic Oversight and Support | LES | Recruited, in position | |

# APPENDIX A -- PRIORITIZATION REQUIRED

**Table A.1: Continuous Nature of SNU Prioritization to Reach Epidemic Control**

| County | COP | Prioritization | APR Results Projected | Treatment Coverage at APR by Age and Sex | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | <15Yrs Coverage | 15-24 Male Coverage | 15-24 Female Coverage | 25+ Male Coverage | 25+ Female Coverage | Overall Coverage |
| Nairobi County | COP15 | Scaleup Sat | 125,705 | 94% | | | 68% | 96% | 73% |
| Nairobi County | COP16 | Scaleup Sat | 141,541 | 92% | 69% | 52% | 70% | 98% | 83% |
| Nairobi County | COP17 | Scaleup Sat | 142,560 | 90% | 60% | 46% | 71% | 100% | 83% |
| Nairobi County | COP18 | Scaleup Sat | 158,678 | 100% | 82% | 82% | 82% | 102% | 93% |
| Nairobi county | COP19 | EVOLVE | 199,527 | 65% | 144% | 106% | 93% | 106% | 101% |
| Nairobi county | COP20 | EVOLVE | 163,751 | 160% | 118% | 80% | 80% | 97% | 92% |
| Homabay | COP15 | Scaleup Sat | 92,465 | 91% | | | 49% | 97% | 58% |
| Homabay | COP16 | Scaleup Sat | 98,500 | 95% | 22% | 29% | 47% | 92% | 62% |
| Homabay | COP17 | Scaleup Sat | 99,734 | 93% | 30% | 38% | 47% | 89% | 63% |
| Homabay | COP18 | Scaleup Sat | 117,833 | 98% | 51% | 58% | 64% | 92% | 75% |
| Homabay | COP19 | EVOLVE | 117,957 | 89% | 92% | 100% | 99% | 73% | 85% |
| Homabay | COP20 | EVOLVE | 115,992 | 198% | 40% | 72% | 75% | 83% | 81% |
| Kisumu | COP15 | Scaleup Sat | 92,212 | 86% | | | 56% | 105% | 64% |
| Kisumu | COP16 | Scaleup Sat | 97,973 | 87% | 49% | 38% | 56% | 92% | 68% |
| Kisumu | COP17 | Scaleup Sat | 98,770 | 85% | 43% | 37% | 53% | 98% | 68% |
| Kisumu | COP18 | Scaleup Sat | 108,227 | 92% | 52% | 60% | 65% | 92% | 75% |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Kisumu | COP19 | EVOLVE | 122,966 | 77% | 112% | 92% | 83% | 66% | 76% |
| Kisumu | COP20 | EVOLVE | 111,032 | 220% | 40% | 55% | 71% | 83% | 78% |
| Siaya | COP15 | Scaleup Sat | 73,440 | 87% | | | 49% | 97% | 58% |
| Siaya | COP16 | Scaleup Sat | 78,891 | 91% | 37% | 34% | 47% | 88% | 62% |
| Siaya | COP17 | Scaleup Sat | 79,399 | 90% | 31% | 29% | 49% | 91% | 63% |
| Siaya | COP18 | Scaleup Sat | 94,630 | 99% | 60% | 63% | 64% | 88% | 75% |
| Siaya | COP19 | EVOLVE | 95,346 | 81% | 113% | 112% | 99% | 72% | 87% |
| Siaya | COP20 | EVOLVE | 93,597 | 215% | 31% | 63% | 69% | 88% | 81% |
| Migori | COP15 | Scaleup Sat | 59,912 | 107% | | | 57% | 122% | 72% |
| Migori | COP16 | Scaleup Sat | 64,577 | 113% | 34% | 47% | 56% | 111% | 77% |
| Migori | COP17 | Scaleup Sat | 65,673 | 113% | 32% | 46% | 58% | 114% | 79% |
| Migori | COP18 | Scaleup Sat | 72,317 | 108% | 45% | 62% | 76% | 110% | 87% |
| Migori | COP19 | EVOLVE | 79,087 | 78% | 69% | 92% | 96% | 73% | 82% |
| Migori | COP20 | EVOLVE | 75,201 | 242% | 39% | 88% | 75% | 91% | 88% |
| Kiambu | COP15 | Scaleup Agg | 31,885 | 82% | | | 60% | 44% | 45% |
| Kiambu | COP16 | Scaleup Sat | 35,239 | 77% | 61% | 39% | 59% | 45% | 50% |
| Kiambu | COP17 | Scaleup Agg | 35,494 | 74% | 51% | 31% | 60% | 47% | 50% |
| Kiambu | COP18 | Scaleup Agg | 52,873 | 104% | 63% | 63% | 63% | 79% | 75% |
| Kiambu | COP19 | REBOOT | 44,543 | 54% | 68% | 90% | 64% | 103% | 85% |
| Kiambu | COP20 | REBOOT | 47,508 | 125% | 88% | 58% | 63% | 80% | 75% |
| Mombasa | COP15 | Scaleup Sat | 40,885 | 71% | | | 106% | 90% | 75% |
| Mombasa | COP16 | Scaleup Sat | 43,018 | 63% | 133% | 81% | 85% | 74% | 79% |
| Mombasa | COP17 | Scaleup Sat | 42,678 | 54% | 53% | 31% | 103% | 86% | 79% |
| Mombasa | COP18 | Scaleup Sat | 48,879 | 90% | 150% | 88% | 87% | 86% | 90% |
| Mombasa | COP19 | EVOLVE | 50,054 | 97% | 243% | 172% | 97% | 91% | 105% |
| Mombasa | COP20 | EVOLVE | 44,795 | 155% | 56% | 43% | 54% | 85% | 71% |
| Kakamega | COP15 | Scaleup Agg | 35,526 | 86% | | | 60% | 92% | 70% |
| Kakamega | COP16 | Scaleup Agg | 38,467 | 92% | 75% | 83% | 61% | 80% | 76% |
| Kakamega | COP17 | Scaleup Sat | 38,613 | 89% | 74% | 85% | 61% | 81% | 76% |

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|---|---|---|---|---|---|---|---|---|---|
| Kakamega | COP18 | Scaleup Sat | 45,506 | 99% | 100% | 91% | 72% | 97% | 89% |
| Kakamega | COP19 | EVOLVE | 43,992 | 68% | 80% | 114% | 87% | 94% | 90% |
| Kakamega | COP20 | EVOLVE | 44,297 | 400% | 81% | 54% | 96% | 86% | 92% |
| Nakuru | COP15 | Scaleup Agg | 32,336 | 71% | | | 72% | 110% | 78% |
| Nakuru | COP16 | Scaleup Agg | 35,530 | 69% | 57% | 48% | 74% | 109% | 86% |
| Nakuru | COP17 | Scaleup Sat | 35,757 | 68% | 58% | 49% | 75% | 110% | 87% |
| Nakuru | COP18 | Scaleup Sat | 41,217 | 90% | 81% | 81% | 81% | 121% | 100% |
| Nakuru | COP19 | REBOOT | 43,427 | 72% | 64% | 91% | 74% | 75% | 75% |
| Nakuru | COP20 | REBOOT | 42,051 | 219% | 59% | 50% | 64% | 66% | 67% |
| Busia | COP15 | Scaleup Sat | 30,042 | 76% | | | 75% | 101% | 78% |
| Busia | COP16 | Scaleup Sat | 32,385 | 76% | 63% | 61% | 76% | 96% | 84% |
| Busia | COP17 | Scaleup Sat | 32,941 | 76% | 53% | 56% | 78% | 99% | 85% |
| Busia | COP18 | Scaleup Sat | 34,502 | 95% | 72% | 72% | 77% | 101% | 90% |
| Busia | COP19 | SCALE | 36,213 | 79% | 61% | 94% | 98% | 101% | 95% |
| Busia | COP20 | SCALE | 33,248 | 208% | 61% | 44% | 90% | 81% | 83% |
| Kisii | COP15 | Scaleup Agg | 25,737 | 113% | | | 54% | 135% | 76% |
| Kisii | COP16 | Scaleup Sat | 27,901 | 114% | 34% | 40% | 55% | 128% | 82% |
| Kisii | COP17 | Scaleup Sat | 28,176 | 110% | 35% | 41% | 56% | 130% | 83% |
| Kisii | COP18 | Scaleup Sat | 31,633 | 113% | 43% | 55% | 76% | 130% | 93% |
| Kisii | COP19 | REBOOT | 32,055 | 65% | 54% | 64% | 78% | 71% | 71% |
| Kisii | COP20 | REBOOT | 33,233 | 240% | 52% | 76% | 60% | 79% | 75% |
| Machakos | COP15 | Scaleup Agg | 21,477 | 101% | | | 75% | 83% | 66% |
| Machakos | COP16 | Scaleup Sat | 22,063 | 91% | 40% | 22% | 72% | 79% | 68% |
| Machakos | COP17 | Scaleup Sat | 22,435 | 93% | 44% | 25% | 70% | 80% | 69% |
| Machakos | COP18 | Scaleup Sat | 29,187 | 102% | 74% | 74% | 74% | 101% | 90% |
| Machakos | COP19 | SCALE | 27,310 | 98% | 94% | 141% | 70% | 89% | 88% |
| Machakos | COP20 | SCALE | 27,975 | 161% | 97% | 51% | 64% | 71% | 71% |
| Kilifi | COP15 | Scaleup Agg | 20,566 | 84% | | | 74% | 82% | 65% |
| Kilifi | COP16 | Scaleup Agg | 20,663 | 80% | 62% | 43% | 59% | 72% | 65% |

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|---|---|---|---|---|---|---|---|---|---|
| Kilifi | COP17 | Scaleup Agg | 21,030 | 83% | 71% | 56% | 58% | 70% | 66% |
| Kilifi | COP18 | Scaleup Agg | 23,564 | 99% | 91% | 57% | 64% | 79% | 74% |
| Kilifi | COP19 | REBOOT | 29,982 | 107% | 128% | 97% | 61% | 71% | 75% |
| Kilifi | COP20 | REBOOT | 26,500 | 229% | 79% | 60% | 67% | 70% | 73% |
| Bungoma | COP15 | Scaleup Agg | 21,327 | 84% | | | 60% | 95% | 71% |
| Bungoma | COP16 | Scaleup Sat | 22,178 | 82% | 66% | 72% | 59% | 82% | 74% |
| Bungoma | COP17 | Scaleup Sat | 22,485 | 82% | 69% | 69% | 60% | 84% | 75% |
| Bungoma | COP18 | Scaleup Sat | 26,931 | 101% | 71% | 87% | 71% | 100% | 89% |
| Bungoma | COP19 | EVOLVE | 27,749 | 89% | 63% | 121% | 96% | 106% | 100% |
| Bungoma | COP20 | EVOLVE | 25,791 | 102% | 29% | 111% | 29% | 209% | 76% |
| Makueni | COP15 | Scaleup Agg | 15,012 | 87% | | | 53% | 66% | 51% |
| Makueni | COP16 | Scaleup Sat | 15,234 | 84% | 24% | 16% | 51% | 61% | 52% |
| Makueni | COP17 | Scaleup Sat | 15,367 | 80% | 26% | 19% | 50% | 62% | 52% |
| Makueni | COP18 | Scaleup Sat | 26,286 | 98% | 75% | 75% | 75% | 101% | 90% |
| Makueni | COP19 | SCALE | 19,012 | 97% | 80% | 120% | 59% | 74% | 75% |
| Makueni | COP20 | SCALE | 19,131 | 189% | 116% | 59% | 75% | 72% | 76% |
| Kitui | COP15 | Scaleup Agg | 17,303 | 109% | | | 57% | 78% | 60% |
| Kitui | COP16 | Scaleup Sat | 17,470 | 104% | 30% | 19% | 59% | 71% | 60% |
| Kitui | COP17 | Scaleup Sat | 17,591 | 101% | 32% | 21% | 52% | 74% | 61% |
| Kitui | COP18 | Scaleup Sat | 25,882 | 109% | 73% | 73% | 73% | 101% | 90% |
| Kitui | COP19 | SCALE | 22,166 | 95% | 77% | 119% | 59% | 75% | 75% |
| Kitui | COP20 | SCALE | 21,959 | 179% | 113% | 48% | 65% | 64% | 68% |
| Murang'a | COP15 | Scaleup Agg | 11,648 | 89% | | | 57% | 42% | 43% |
| Murang'a | COP16 | Scaleup Agg | 12,970 | 91% | 42% | 27% | 56% | 45% | 48% |
| Murang'a | COP17 | Scaleup Agg | 13,096 | 85% | 55% | 28% | 58% | 45% | 48% |
| Murang'a | COP18 | Scaleup Agg | 20,297 | 85% | 65% | 65% | 65% | 79% | 75% |
| Murang'a | COP19 | SCALE | 20,220 | 40% | 64% | 84% | 56% | 91% | 75% |
| Murang'a | COP20 | SCALE | 16,354 | 133% | 109% | 80% | 66% | 74% | 74% |
| Uasin Gishu | COP15 | Scaleup Sat | 27,444 | 81% | | | 100% | 142% | 103% |

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|---|---|---|---|---|---|---|---|---|---|
| Uasin Gishu | COP16 | Scaleup Sat | 29,164 | 77% | 78% | 61% | 99% | 137% | 109% |
| Uasin Gishu | COP17 | Scaleup Sat | 29,244 | 79% | 81% | 44% | 99% | 141% | 109% |
| Uasin Gishu | COP18 | Scaleup Sat | 31,604 | 100% | 97% | 87% | 101% | 143% | 118% |
| Uasin Gishu | COP19 | SCALE | 31,024 | 66% | 73% | 91% | 87% | 82% | 82% |
| Uasin Gishu | COP20 | SCALE | 31,566 | 155% | 59% | 45% | 54% | 68% | 63% |
| Trans Nzoia | COP15 | Scaleup Agg | 12,968 | 48% | | | 41% | 72% | 50% |
| Trans Nzoia | COP16 | Scaleup Sat | 13,665 | 45% | 36% | 30% | 45% | 65% | 52% |
| Trans Nzoia | COP17 | Scaleup Sat | 13,280 | 41% | 46% | 26% | 42% | 65% | 51% |
| Trans Nzoia | COP18 | Scaleup Sat | 23,417 | 90% | 71% | 71% | 71% | 108% | 90% |
| Trans Nzoia | COP19 | REBOOT | 23,663 | 80% | 57% | 82% | 67% | 70% | 70% |
| Trans Nzoia | COP20 | REBOOT | 16,328 | 160% | 42% | 44% | 44% | 53% | 52% |
| Meru | COP15 | Scaleup Agg | 17,066 | 101% | | | 81% | 80% | 66% |
| Meru | COP16 | Scaleup Sat | 16,994 | 86% | 40% | 29% | 77% | 71% | 65% |
| Meru | COP17 | Scaleup Sat | 17,007 | 82% | 39% | 22% | 75% | 74% | 65% |
| Meru | COP18 | Scaleup Sat | 23,287 | 108% | 73% | 73% | 90% | 93% | 89% |
| Meru | COP19 | SCALE | 20,193 | 81% | 81% | 125% | 80% | 77% | 82% |
| Meru | COP20 | SCALE | 21,248 | 159% | 105% | 57% | 55% | 61% | 63% |
| Nyamira | COP15 | Scaleup Agg | 12,257 | 81% | | | 36% | 89% | 50% |
| Nyamira | COP16 | Scaleup Agg | 13,055 | 83% | 34% | 41% | 35% | 75% | 54% |
| Nyamira | COP17 | Scaleup Sat | 13,207 | 82% | 34% | 42% | 35% | 76% | 54% |
| Nyamira | COP18 | Scaleup Sat | 21,799 | 97% | 79% | 79% | 79% | 104% | 90% |
| Nyamira | COP19 | SCALE | 16,883 | 80% | 109% | 98% | 86% | 59% | 75% |
| Nyamira | COP20 | SCALE | 14,009 | 352% | 74% | 83% | 72% | 87% | 87% |
| Kwale | COP15 | Scaleup Agg | 7,501 | 44% | | | 34% | 40% | 31% |
| Kwale | COP16 | Scaleup Agg | 8,063 | 45% | 52% | 46% | 25% | 31% | 34% |
| Kwale | COP17 | Scaleup Agg | 8,255 | 42% | 27% | 27% | 30% | 38% | 35% |
| Kwale | COP18 | Scaleup Agg | 17,807 | 75% | 61% | 61% | 61% | 85% | 75% |
| Kwale | COP19 | REBOOT | 16,959 | 115% | 84% | 102% | 57% | 75% | 75% |
| Kwale | COP20 | REBOOT | 12,259 | 214% | 92% | 81% | 55% | 60% | 65% |

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|---|---|---|---|---|---|---|---|---|---|
| Turkana | COP15 | Scaleup Agg | 6,205 | 36% | | | 28% | 34% | 28% |
| Turkana | COP16 | Scaleup Agg | 7,253 | 42% | 90% | 36% | 22% | 31% | 32% |
| Turkana | COP17 | Scaleup Agg | 7,212 | 42% | 95% | 36% | 22% | 30% | 32% |
| Turkana | COP18 | Scaleup Agg | 16,780 | 75% | 131% | 59% | 52% | 89% | 75% |
| Turkana | COP19 | REBOOT | 19,188 | 84% | 130% | 83% | 61% | 70% | 72% |
| Turkana | COP20 | REBOOT | 8,594 | 114% | 21% | 35% | 33% | 40% | 39% |
| Kajiado | COP15 | Scaleup Agg | 10,640 | 42% | | | 46% | 76% | 52% |
| Kajiado | COP16 | Scaleup Agg | 10,796 | 40% | 31% | 30% | 44% | 70% | 53% |
| Kajiado | COP17 | Scaleup Agg | 10,838 | 38% | 38% | 40% | 43% | 68% | 53% |
| Kajiado | COP18 | Scaleup Agg | 15,100 | 58% | 62% | 62% | 62% | 90% | 75% |
| Kajiado | COP19 | REBOOT | 21,759 | 65% | 65% | 93% | 76% | 74% | 75% |
| Kajiado | COP20 | REBOOT | 15,278 | 162% | 35% | 38% | 40% | 53% | 49% |
| Vihiga | COP15 | Sustained | 12,685 | 87% | | | 60% | 83% | 65% |
| Vihiga | COP16 | Sustained | 13,035 | 90% | 63% | 70% | 56% | 70% | 67% |
| Vihiga | COP17 | Scaleup Sat | 13,054 | 82% | 64% | 71% | 56% | 71% | 67% |
| Vihiga | COP18 | Scaleup Sat | 17,346 | 100% | 71% | 71% | 71% | 103% | 90% |
| Vihiga | COP19 | SCALE | 15,426 | 69% | 61% | 84% | 80% | 92% | 84% |
| Vihiga | COP20 | SCALE | 16,181 | 306% | 77% | 61% | 75% | 74% | 79% |
| Nyeri | COP15 | Sustained | 15,085 | 147% | | | 111% | 79% | 81% |
| Nyeri | COP16 | Sustained | 15,904 | 128% | 94% | 48% | 102% | 81% | 85% |
| Nyeri | COP17 | Scaleup Sat | 15,949 | 122% | 112% | 48% | 108% | 79% | 85% |
| Nyeri | COP18 | Scaleup Sat | 16,720 | 157% | 98% | 52% | 103% | 85% | 90% |
| Nyeri | COP19 | EVOLVE | 17,124 | 89% | 98% | 63% | 86% | 95% | 90% |
| Nyeri | COP20 | EVOLVE | 18,633 | 105% | 120% | 76% | 61% | 77% | 73% |
| Kericho | COP15 | Sustained | 13,768 | 75% | | | 81% | 110% | 84% |
| Kericho | COP16 | Sustained | 15,584 | 87% | 104% | 80% | 76% | 112% | 95% |
| Kericho | COP17 | Attained | 16,279 | 88% | 115% | 86% | 80% | 116% | 99% |
| Kericho | COP18 | Sustained | 17,169 | 89% | 184% | 86% | 86% | 118% | 105% |
| Kericho | COP19 | EVOLVE | 19,205 | 89% | 217% | 134% | 87% | 85% | 95% |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Kericho | COP20 | EVOLVE | 15,979 | 152% | 67% | 60% | 53% | 84% | 72% |
| Narok | COP15 | Scaleup Agg | 6,985 | 50% | | | 41% | 59% | 44% |
| Narok | COP16 | Scaleup Agg | 7,804 | 49% | 31% | 26% | 55% | 61% | 49% |
| Narok | COP17 | Scaleup Agg | 7,870 | 53% | 35% | 29% | 41% | 61% | 50% |
| Narok | COP18 | Scaleup Agg | 11,838 | 86% | 56% | 56% | 56% | 90% | 75% |
| Narok | COP19 | REBOOT | 15,453 | 82% | 57% | 80% | 65% | 70% | 70% |
| Narok | COP20 | REBOOT | 9,961 | 124% | 27% | 38% | 31% | 49% | 43% |
| Nyandarua | COP15 | Sustained | 6,873 | 142% | | | 70% | 52% | 54% |
| Nyandarua | COP16 | Sustained | 7,299 | 134% | 67% | 34% | 67% | 52% | 57% |
| Nyandarua | COP17 | Scaleup Sat | 7,330 | 126% | 92% | 45% | 71% | 49% | 57% |
| Nyandarua | COP18 | Scaleup Sat | 11,478 | 181% | 69% | 69% | 69% | 95% | 90% |
| Nyandarua | COP19 | SCALE | 10,640 | 67% | 55% | 72% | 50% | 93% | 75% |
| Nyandarua | COP20 | SCALE | 9,749 | 134% | 109% | 77% | 70% | 77% | 78% |
| Kirinyaga | COP15 | Sustained | 8,415 | 119% | | | 87% | 69% | 68% |
| Kirinyaga | COP16 | Sustained | 9,068 | 114% | 60% | 34% | 92% | 70% | 74% |
| Kirinyaga | COP17 | Scaleup Sat | 9,378 | 113% | 61% | 37% | 91% | 74% | 76% |
| Kirinyaga | COP18 | Scaleup Sat | 11,090 | 123% | 76% | 76% | 96% | 88% | 90% |
| Kirinyaga | COP19 | SCALE | 10,670 | 59% | 60% | 80% | 64% | 100% | 83% |
| Kirinyaga | COP20 | SCALE | 10,801 | 129% | 92% | 70% | 64% | 76% | 73% |
| Taita Taveta | COP15 | Sustained | 4,955 | 42% | | | 55% | 52% | 42% |
| Taita Taveta | COP16 | Sustained | 4,880 | 34% | 23% | 11% | 49% | 49% | 41% |
| Taita Taveta | COP17 | Sustained | 4,983 | 39% | 30% | 12% | 51% | 48% | 42% |
| Taita Taveta | COP18 | Sustained | 6,012 | 55% | 41% | 23% | 52% | 58% | 51% |
| Taita Taveta | COP19 | REBOOT | 9,003 | 88% | 86% | 58% | 72% | 77% | 75% |
| Taita Taveta | COP20 | REBOOT | 6,848 | 163% | 102% | 85% | 56% | 77% | 72% |
| Nandi | COP15 | Scaleup Agg | 9,442 | 69% | | | 80% | 118% | 84% |
| Nandi | COP16 | Scaleup Agg | 10,296 | 77% | 70% | 39% | 88% | 113% | 92% |
| Nandi | COP17 | Scaleup Agg | 10,579 | 75% | 56% | 36% | 86% | 121% | 94% |
| Nandi | COP18 | Scaleup Agg | 11,266 | 86% | 82% | 59% | 91% | 121% | 100% |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Nandi | COP19 | SCALE | 12,066 | 77% | 101% | 76% | 70% | 87% | 81% |
| Nandi | COP20 | SCALE | 11,591 | 172% | 46% | 45% | 44% | 64% | 58% |
| Bomet | COP15 | Scaleup Agg | 9,586 | 79% | | | 75% | 122% | 86% |
| Bomet | COP16 | Scaleup Agg | 11,088 | 93% | 74% | 69% | 83% | 122% | 99% |
| Bomet | COP17 | Scaleup Sat | 10,732 | 84% | 62% | 55% | 91% | 115% | 96% |
| Bomet | COP18 | Scaleup Sat | 13,073 | 95% | 97% | 97% | 97% | 142% | 117% |
| Bomet | COP19 | EVOLVE | 11,774 | 91% | 89% | 126% | 101% | 98% | 100% |
| Bomet | COP20 | EVOLVE | 10,439 | 139% | 46% | 54% | 49% | 74% | 65% |
| Embu | COP15 | Sustained | 8,219 | 93% | | | 90% | 93% | 74% |
| Embu | COP16 | Sustained | 7,948 | 91% | 33% | 21% | 79% | 84% | 71% |
| Embu | COP17 | Attained | 8,040 | 90% | 38% | 19% | 81% | 85% | 72% |
| Embu | COP18 | Sustained | 9,972 | 98% | 75% | 75% | 87% | 95% | 90% |
| Embu | COP19 | EVOLVE | 9,948 | 84% | 100% | 153% | 81% | 86% | 90% |
| Embu | COP20 | EVOLVE | 10,341 | 219% | 160% | 70% | 84% | 83% | 87% |
| Tharaka Nithi | COP15 | Sustained | 5,878 | 86% | | | 85% | 78% | 65% |
| Tharaka Nithi | COP16 | Sustained | 5,950 | 77% | 48% | 24% | 76% | 73% | 65% |
| Tharaka Nithi | COP17 | Scaleup Sat | 6,013 | 76% | 44% | 23% | 79% | 74% | 66% |
| Tharaka Nithi | COP18 | Scaleup Sat | 8,138 | 98% | 75% | 75% | 89% | 94% | 90% |
| Tharaka Nithi | COP19 | SCALE | 7,061 | 64% | 89% | 134% | 79% | 77% | 81% |
| Tharaka Nithi | COP20 | SCALE | 7,253 | 194% | 163% | 69% | 88% | 76% | 83% |
| Laikipia | COP15 | Sustained | 6,895 | 87% | | | 83% | 122% | 89% |
| Laikipia | COP16 | Sustained | 7,692 | 88% | 76% | 53% | 78% | 128% | 99% |
| Laikipia | COP17 | Scaleup Agg | 7,814 | 88% | 108% | 53% | 89% | 122% | 101% |
| Laikipia | COP18 | Scaleup Agg | 5,933 | 75% | 78% | 55% | 62% | 91% | 76% |
| Laikipia | COP19 | SCALE | 8,796 | 124% | 86% | 83% | 77% | 75% | 81% |
| Laikipia | COP20 | SCALE | 8,851 | 283% | 100% | 84% | 70% | 99% | 92% |
| Baringo | COP15 | Sustained | 3,001 | 57% | | | 49% | 74% | 54% |
| Baringo | COP16 | Sustained | 3,167 | 57% | 35% | 32% | 45% | 72% | 57% |
| Baringo | COP17 | Sustained | 3,222 | 58% | 27% | 19% | 46% | 77% | 58% |

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|---|---|---|---|---|---|---|---|---|---|
| Baringo | COP18 | Sustained | 3,855 | 75% | 53% | 53% | 53% | 83% | 69% |
| Baringo | COP19 | SCALE | 5,172 | 107% | 61% | 85% | 69% | 74% | 75% |
| Baringo | COP20 | SCALE | 4,594 | 134% | 41% | 40% | 46% | 59% | 55% |
| West Pokot | COP15 | Sustained | 2,173 | 42% | | | 42% | 63% | 45% |
| West Pokot | COP16 | Sustained | 3,201 | 97% | 166% | 101% | 41% | 61% | 67% |
| West Pokot | COP17 | Sustained | 3,523 | 89% | 206% | 113% | 42% | 71% | 74% |
| West Pokot | COP18 | Sustained | 3,880 | 77% | 173% | 108% | 67% | 77% | 81% |
| West Pokot | COP19 | REBOOT | 5,238 | 64% | 165% | 151% | 73% | 59% | 75% |
| West Pokot | COP20 | REBOOT | 2,689 | 131% | 31% | 43% | 44% | 67% | 58% |
| Elgeyo Marakwet | COP15 | Sustained | 2,419 | 54% | | | 48% | 78% | 55% |
| Elgeyo Marakwet | COP16 | Sustained | 2,722 | 54% | 25% | 48% | 50% | 79% | 62% |
| Elgeyo Marakwet | COP17 | Scaleup Sat | 2,645 | 53% | 26% | 27% | 48% | 81% | 60% |
| Elgeyo Marakwet | COP18 | Scaleup Sat | 3,944 | 90% | 76% | 76% | 76% | 104% | 90% |
| Elgeyo Marakwet | COP19 | SCALE | 4,194 | 81% | 66% | 94% | 76% | 71% | 75% |
| Elgeyo Marakwet | COP20 | SCALE | 3,596 | 147% | 30% | 38% | 38% | 56% | 50% |
| Isiolo | COP15 | Sustained Com | 2,095 | 107% | | | 71% | 69% | 58% |
| Isiolo | COP16 | Sustained Com | 2,176 | 107% | 21% | 18% | 72% | 65% | 60% |
| Isiolo | COP17 | Sustained Com | 2,066 | 102% | 20% | 15% | 67% | 63% | 57% |
| Isiolo | COP18 | Sustained Com | 2,386 | 102% | 51% | 51% | 56% | 72% | 66% |
| Isiolo | COP19 | GOK/TRANSITION | - | 0% | 0% | 0% | 0% | 0% | 0% |
| Isiolo | COP20 | GOK/TRANSITION | 0 | 161% | 55% | 48% | 57% | 54% | 58% |
| Mandera | COP15 | Sustained Com | 481 | 5% | | | 52% | 14% | 14% |
| Mandera | COP16 | Sustained Com | 513 | 7% | 45% | 22% | 33% | 9% | 15% |
| Mandera | COP17 | Sustained Com | 525 | 8% | 48% | 22% | 35% | 9% | 16% |
| Mandera | COP18 | Sustained Com | 542 | 50% | 46% | 12% | 7% | 7% | 16% |
| Mandera | COP19 | GOK/TRANSITION | - | 0% | 0% | 0% | 0% | 0% | 0% |
| Mandera | COP20 | GOK/TRANSITION | 0 | 25% | 37% | 27% | 48% | 47% | 44% |
| Samburu | COP15 | Sustained | 1,092 | 63% | | | 30% | 48% | 37% |
| Samburu | COP16 | Sustained | 1,399 | 79% | 74% | 131% | 27% | 31% | 47% |

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|---|---|---|---|---|---|---|---|---|---|
| Samburu | COP17 | Sustained | 1,424 | 83% | 96% | 126% | 30% | 29% | 48% |
| Samburu | COP18 | Sustained | 1,750 | 70% | 96% | 136% | 48% | 42% | 59% |
| Samburu | COP19 | REBOOT | 2,669 | 78% | 131% | 263% | 73% | 45% | 74% |
| Samburu | COP20 | REBOOT | 1,770 | 257% | 41% | 63% | 54% | 79% | 74% |
| Marsabit | COP15 | Sustained Com | 1,421 | 79% | | | 54% | 64% | 50% |
| Marsabit | COP16 | Sustained Com | 1,205 | 47% | 106% | 78% | 39% | 27% | 42% |
| Marsabit | COP17 | Sustained Com | 1,219 | 57% | 106% | 79% | 29% | 31% | 43% |
| Marsabit | COP18 | Sustained Com | 1,352 | 85% | 110% | 79% | 41% | 31% | 48% |
| Marsabit | COP19 | GOK/TRANSITION | - | 0% | 0% | 0% | 0% | 0% | 0% |
| Marsabit | COP20 | GOK/TRANSITION | 0 | 82% | 52% | 28% | 35% | 39% | 39% |
| Tana River | COP15 | Sustained Com | 894 | 41% | | | 35% | 41% | 32% |
| Tana River | COP16 | Sustained Com | 1,008 | 44% | 62% | 50% | 28% | 32% | 36% |
| Tana River | COP17 | Sustained Com | 1,020 | 46% | 58% | 49% | 30% | 33% | 37% |
| Tana River | COP18 | Sustained Com | 1,061 | 61% | 47% | 38% | 29% | 38% | 38% |
| Tana River | COP19 | GOK/TRANSITION | - | 0% | 0% | 0% | 0% | 0% | 0% |
| Tana River | COP20 | GOK/TRANSITION | 0 | 116% | 40% | 53% | 41% | 63% | 56% |
| Garissa | COP15 | Sustained Com | 1,087 | 17% | | | 100% | 53% | 43% |
| Garissa | COP16 | Sustained Com | 1,158 | 13% | 113% | 94% | 66% | 31% | 46% |
| Garissa | COP17 | Sustained Com | 1,223 | 16% | 115% | 100% | 68% | 33% | 48% |
| Garissa | COP18 | Sustained Com | 1,333 | 50% | 82% | 68% | 47% | 48% | 53% |
| Garissa | COP19 | GOK/TRANSITION | - | 0% | 0% | 0% | 0% | 0% | 0% |
| Garissa | COP20 | GOK/TRANSITION | 0 | 61% | 28% | 43% | 44% | 58% | 52% |
| Lamu | COP15 | Sustained Com | 1,125 | 78% | | | 61% | 56% | 49% |
| Lamu | COP16 | Sustained Com | 1,218 | 69% | 59% | 42% | 54% | 52% | 53% |
| Lamu | COP17 | Sustained Com | 1,222 | 63% | 24% | 25% | 62% | 57% | 53% |
| Lamu | COP18 | Sustained Com | 1,379 | 75% | 46% | 46% | 46% | 68% | 59% |
| Lamu | COP19 | GOK/TRANSITION | - | 0% | 0% | 0% | 0% | 0% | 0% |
| Lamu | COP20 | GOK/TRANSITION | 0 | 170% | 85% | 87% | 58% | 71% | 70% |
| Wajir | COP15 | Sustained Com | 214 | 8% | | | 51% | 18% | 17% |

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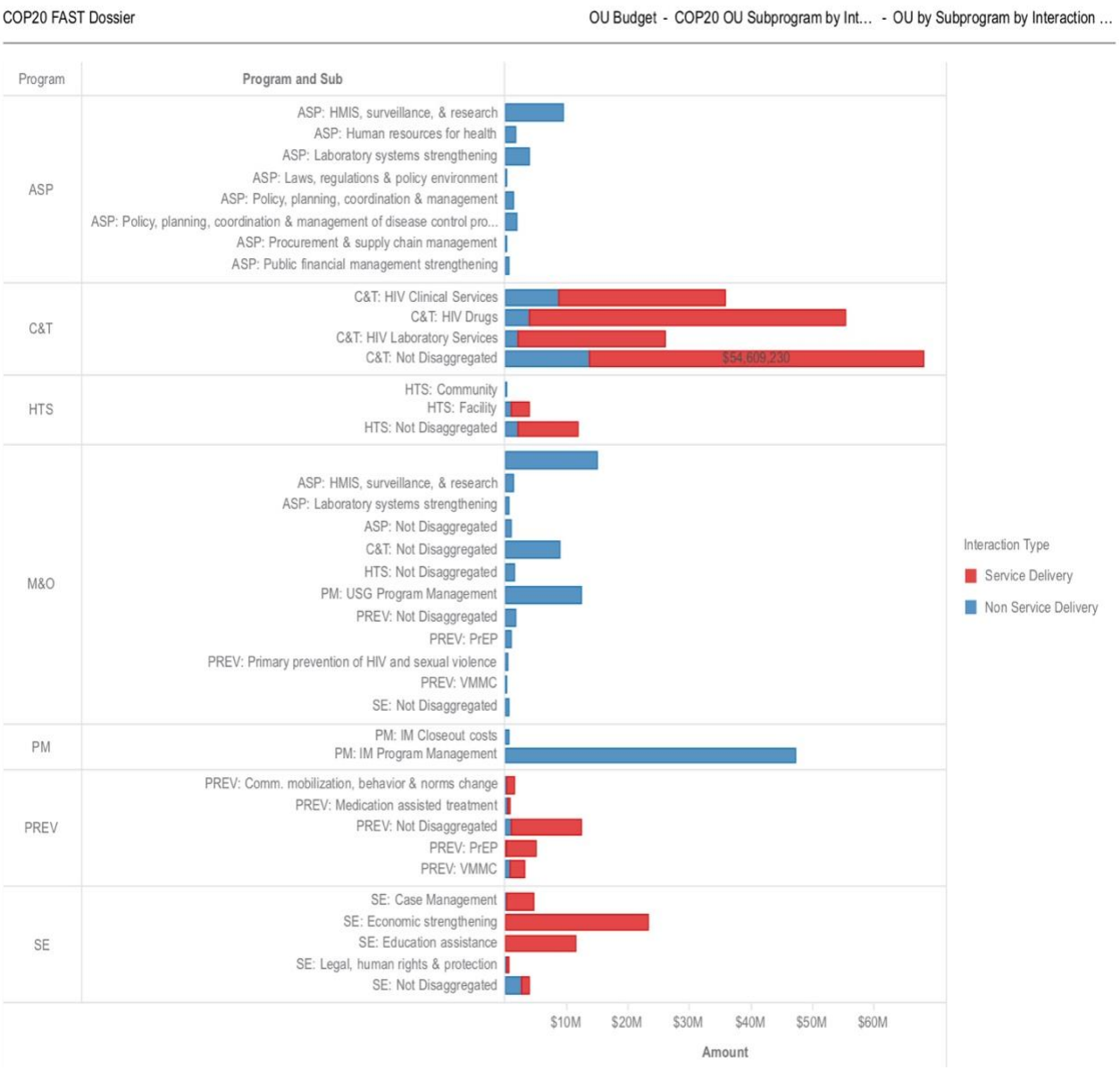
|---|---|---|---|---|---|---|---|---|---|
| Wajir | COP16 | Sustained Com | 249 | 11% | 65% | 41% | 31% | 10% | 19% |
| Wajir | COP17 | Sustained Com | 258 | 11% | 68% | 43% | 32% | 10% | 20% |
| Wajir | COP18 | Sustained Com | 252 | 50% | 27% | 17% | 13% | 13% | 20% |
| Wajir | COP19 | GOK/TRANSITION | - | 0% | 0% | 0% | 0% | 0% | 0% |
| Wajir | COP20 | GOK/TRANSITION | | | | | | | |

# APPENDIX B – Budget Profile and Resource Projections

**Table B.1.1 COP18 Budget by Program, Subprogram, and Interaction Type**



| Table B.1.2 COP20 Total Planning Level | | |
|---|---|---|
| **Applied Pipeline** | **New Funding** | **Total Spend** |
| **$46,343,557** | **$332,790,446** | **$379,134,003** |
| *Data included in Table B.1.2 should match FACTS Info records and total applied pipeline amount required in PLL guidance. | | |

## Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)

| PEPFAR Budget Code | Budget Code Description | Amount Allocated |
|---|---|---|
| MTCT | Mother to Child Transmission | $ 1,469,752 |
| HVAB/Y | Abstinence/Be Faithful Prevention/Youth | $ 50,000 |
| HVOP | Other Sexual Prevention | $ 22,255,473 |
| IDUP | Injecting and Non-Injecting Drug Use | $ 1,119,316 |
| HMBL | Blood Safety | |
| HMIN | Injection Safety | |
| CIRC | Male Circumcision | $ 3,916,417 |
| HVCT | Counseling and Testing | $ 18,518,104 |
| HBHC | Adult Care and Support | $ 3,014,308 |
| PDCS | Pediatric Care and Support | $ 2,125,871 |
| HKID | Orphans and Vulnerable Children | $ 48,571,734 |
| HTXS | Adult Treatment | $ 151,922,504 |
| HTXD | ARV Drugs | $ 45,804,540 |
| HVTB | TB/HIV Care | $ 7,841,553 |
| HLAB | Lab | $ 4,476,012 |
| HVSI | Strategic Information | $ 11,427,317 |
| OHSS | Health Systems Strengthening | $ 6,119,031 |
| HVMS | Management and Operations | $ 4,158,514 |
| **TOTAL** | | **$ 332,790,446** |

# APPENDIX C – Tables and Systems Investments for Section 6.0

See attached files.

# APPENDIX D– Minimum Program Requirements

The minimum program requirements (MPRs) for continued PEPFAR support include:

| Program | MPR | Progress |
|---|---|---|
| **Care and Treatment** | 1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups. a | Kenya is meeting this requirement having adopted Test and Start policy and guidelines. Current Kenya guidelines (2018 ART) include same day initiation of ART, i.e. PLHIV is identified and he or she is linked to care to begin treatment. This guideline is foundational to our HIV public health approach. All COP20 treatment IP work plans will reflect fidelity to achieve >95% linkage rate of identified positive clients across all age, sex, and risk groups. Treatment IP work plans will include a plan for same day initiation for newly-identified clients or a return to care plan for identified known positives. |
| | 2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.b | Kenya PEPFAR team is working in collaboration with GOK to ensure the TLD policy includes an option for informed consent for HIV positive women of child-bearing age. The country is in progress of removing all nevirapine based regimens by end of March 2020. The draft language to be put in the Ministry of Health circular to all counties and health facilities that support implementation of rapid optimization of TLD to all PLHIV was discussed with representatives of GOK and agreed upon March 5, 2020 at the Johannesburg COP meeting. |
| | 3. Adoption and implementation of differentiated service delivery (DSD) models, including six-month MMD/MMS and delivery models to improve identification and ARV coverage of men and adolescents.c | Kenya has national DSD guidelines that were released in 2016 and a majority of patients are on MMD and multi-month prescriptions. In COP20, the country will revise national DSD guidelines on criteria for DSD and community models. Commodity forecasting and |

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| | | procurement will be done to ensure adequate stock to support MMD/MMS. |
| | 4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of COP20, and co-trimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[d] | Kenya is meeting this requirement. It has a policy in place and implementation in progress with over 90% of all PLHIV in care and treatment having been initiated on TPT. In COP20, the country will focus on ensuring capacity within the GOK to mop up the remaining cohort of PLHIV eligible for TPT, ensuring improved documentation, reporting, and strengthening of pharmacovigilance. The country will also focus on finalization of policy change and guidelines and introduction of 3HP |
| | 5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual VL testing and results delivered to caregiver within 4 weeks. | This is ongoing. Ministry of Health has successfully completed VL/EID optimization activities (e.g., testing, receipt of results, networks) and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups. |
| **Case Finding** | 1. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children aged <19 years with an HIV positive biological parent must be tested for HIV.[e] | This policy is done. Implementation is in progress. Kenya HTS guidelines (reprint 2016) include index testing as a promising modality. In addition, Kenya launched *HIV Self-Testing and Assisted Partner Notification Services* guidance document in 2019 that emphasizes implementation of the 5Cs of testing and principles of index testing (pg. 49-50). Kenya is developing an enhanced guidance document for index testing that includes consent procedures emphasizing confidentiality and enhanced monitoring of intimate partner violence (IPV). The draft language is to be included in a Ministry of Health circular to all counties and health facilities on scaling up index testing with fidelity and safeguards. This language was discussed and agreed upon with GOK representatives on March 5, 2020 at the Johannesburg COP meeting. |

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| **Prevention and OVC** | 1. Direct and immediate assessment for - and offer of - prevention services, including pre-exposure prophylaxis (PrEP), to HIV negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV negative partners of index cases, KP and adult men engaged in high-risk sex practices*).* [f] | Kenya has adopted and plans to offer combination prevention services including HIV prevention and is in the process of establishing prevention centers for community education, assessment, and provision of prevention services including PrEP and referral. The national AART policy guidelines developed in 2016 provides for the provision of PrEP to any individual who is at substantial risk of acquiring HIV regardless of population, provided they meet the eligibility criteria. The guidelines provide for PrEP provision both at the community and in health facilities.<br><br>Via COP20, Kenya is expanding the provision of PrEP by integrating service provision into the key service provision areas among highly vulnerable populations. Using targeted HTS as a platform, clients will be screened and tested and the vulnerable sero-negative individuals evaluated for suitability and offered PrEP.<br><br>Specific targets have been allocated in COP20 for the most vulnerable populations including MNCH and KP clients in addition to the discordant and AGYW populations. Kenya has conducted a study on the provision of PrEP in MNCH to PBFW and important lessons were learnt. Services will be scaled up in 2020 to achieve integration. A combination prevention will be followed to allow for choice and fidelity. |
| | 2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC aged 0-17 years, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection; 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV; 3) reducing risk for adolescent girls in high HIV-burden areas and for | Kenya is addressing the requirement of ensuring that all the eligible OVC are identified, assessed, enrolled, and served with an appropriate package of comprehensive and preventive services. Family-centered case management and tracking of graduation benchmarks will take place. In COP20, Kenya will ensure that the distinct, comprehensive package of services for families with known risks as well as preventive services are well defined and implemented. |

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| | girls and boys aged 9-14 years in regard to primary prevention of sexual violence and HIV. | COP20 will further support Kenya facilitating access to HTS for at-risk OVC, ensuring those who are HIV positive are linked to treatment, monitoring adherence and viral suppression (including that of HIV positive caregivers with sub-optimal retention as a safeguard for children).<br><br>Kenya is also focused on primary prevention of HIV and violence targeting pre-and adolescent boys and girls aged 9-14 years with interventions that prevent violence, delay sexual debut and prevent HIV, using evidence-based materials that also target families and communities. |
| **Policy and Public Health Systems Support** | 1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[g] | All HIV, TB and related services are free in all public health facilities. Under the UHC roll out, this will be extended to include more services in all public health facilities. |
| | 2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[h] | Kenya has institutionalized QM systems, plans and workforce capacities to ensure continuous program and service delivery QI. While the health ministry now has a national QA framework to guide implementation, cascading and sustaining gains to county level for service delivery and laboratory QA systems remains an area of focus. The IPs will support HIV/AIDs related CQI activities through their workplans, similarly the same will be incorporated in county MOU documents. |
| | 3. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention. | This is an activity that is in progress and has been prioritized in COP20. PEPFAR has had discussions with Ministry of Health through NASCOP and NACC, and civil society through NEPHAK, on how to continue supporting this activity. The priority activities are demand creation and provision of IEC materials across the counties. PEPFAR Kenya has set aside resources |

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| | | through the Ministry of Health COAG to support these activities in this COP. |
| | 4. Clear evidence of agency progress toward local, indigenous partner direct funding. | Agencies are working toward awarding more agreements and contracts to local partners for service delivery and systems strengthening. This is reflected in the new awards and designs for the various agencies. Discussion are on course to have the county government receive direct funding to implement various awards. |
| | 5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year-after-year increased resources expended. | While public sector contributions to HIV/AIDS have increased from 18.8% in Kenya Fiscal Year (KFY) 2012/13 to 22.1% in KFY 2015/16, donors remain the predominant source of HIV financing, contributing 62.3% of HIV expenditures in KFY 2015/16. The remainder of shares are borne by households through out-of-pocket spending and employers at 9% and 6.5% respectively.<br><br>Kenya's contribution as part of its Global Fund (GF) counterpart-financing requirement was $22 million in 2017/18 and $25 million in 2018/19 for procurement of ARVs and test kits and is expected to increase by $25.4 million in KFY 2019/20 as shown by the budget estimates presented to the National Assembly. This is further expected to increase to $31 million by KFY 2020/21 . Nevertheless, donors continue to finance the majority (75% in KFY 2019/20 down from 86.4% in KFY 2018/19) of all ARV needs and all HIV test kits in Kenya. |

| | | |
|---|---|---|
| | 6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. | Kenya is meeting the requirement. Kenya has conducted mortuary-based surveillance in two counties (Nairobi in 2015 and Kisumu in 2019) as one-off study activities. COP19 focus is to develop guidelines to transition to routine mortality surveillance, with integration into routine PEPFAR reporting (MER) if feasible. COP20 will focus on finalized National Mortality Surveillance guidelines and a plan for implementing mortality surveillance developed. Implementation of mortality surveillance expected within COP20. |
| | 7. Scale-up of case-based surveillance (CBS) and unique identifiers for patients across all sites. | Kenya is meeting the requirement. In COP19, CBS has focused on Siaya County currently implementing CBS in 21 facilities and plans for rollout to Kakamega and Homabay in March 2020 and grouped rollout in April 2020 for additional 8-10 counties. COP20 will focus on national coverage of CBS rollout and launching of an e-learning module for CBS to support efficient cascading of CBS training to county/sub-county/facility levels.<br><br>Unique identifiers: In COP19 PEPFAR Kenya is working with the Ministry of Health and other stakeholders to develop and implement a policy framework for Unique Patient Identifiers. COP19 activities are progressing well and are on target to meeting the COP19 Benchmark of the National UPI policy framework developed and adopted by key stakeholders at two levels of government.<br><br>COP20 will focus on the implementation of the UPI policy framework starting with the UHC pilot counties – Kisumu, Machakos, Isiolo - and scaling up to the rest of the country. |

[a] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

[b] Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019

[c] Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016

[d] Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

[e] Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 https://www.who.int/hiv/pub/self-testing/hiv-self-testing-guidelines/en/

[f] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en).

[g] The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005

[h] Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

**Site Level MPRs Related to Linkage and Retention**

During FY20 (COP19 implementation), all OUs are expected to fully implement retention-related PEPFAR MPRs at every PEPFAR-supported site, as these have a known impact on continuity of ART. Site level implementation of these 4 elements must be assessed to inform COP20 planning. In addition, an effective tracking and tracing system must be in place at each site.

| | MPRs |
|---|---|
| 1. | Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups. |
| 2. | Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens. |
| 3. | Elimination of all formal and informal user fees affecting access to HIV testing and treatment and prevention in the public sector to ensure access to all direct HIV services and medications, and related services, such as ANC, TB, co-trimoxazole, cervical cancer, PrEP and routine clinical services. |
| 4. | Adoption and implementation of differentiated service delivery models for clinically stable clients that ensures choice between facility and community ART refill pick-up locations and individual or group ART refill models. All models should offer patients the opportunity to get 6 months of medication at a time without requiring repeat appointments or visits. |

# APPENDIX E – Analysis of Placement and Use of Point-of-Care Machines for Early Infant Diagnosis to Optimize EID Testing and Return of Results

**Rationale**

Civil Society Organizations in Kenya wrote the "People's COP20" asking for an increase in funding for the PEPFAR program in Kenya highlighting impacts to test kits, HRH, and retention strategies in addition to improving timely diagnosis of perinatal HIV with point of care (POC) testing. Citing the KENPHIA data, the report describes a large gap in the treatment cascade for children along the cascade. The report describes concerns around the discontinuation of the UNITAID/EGPAF pilot of point of care testing, which was never officially transferred to PEPFAR or NASCOP. The CSOs suggested increased point of care to cover 70% of EID testing platforms with PEPFAR funds to cover $605,000 annually in EID point of care support.

PEPFAR/Kenya has developed this appendix presenting existing evidence of the PMTCT program, gaps, considerations for placement of POC instruments, and additional funding needed. Careful consideration was placed on analyzing existing gaps in early infant diagnosis (EID) coverage, retention, and linkage to ART for HIV-infected infants. The current major challenges include limited retention of mothers and infant's infants in the care cascade, and improving retention may be the most effective method to improve early identification of infants through maternal retention and early linkage to ART. Direct support of POC EID instruments will not directly address retention, however, they may improve timeliness in receiving results linkage to ART initiation, which is an important component of PMTCT programming. Acknowledging the urgent need to reduce the rates of mother-to-children-transmission of HIV (MTCT) in Kenya, PEPFAR/Kenya will support six (6) EID POC instruments in COP20.

**Background**

A robust PMTCT program is an essential component in the sprint to achieve HIV epidemic control across all age and sex bands. EID is the cornerstone to identify infants living with HIV and to provide lifesaving ART; EID helps mitigate the high rates of mortality among infants and young children living with HIV who are not on effective ART. PEPFAR/Kenya is committed to implementing a data-driven PMTCT program that meets the testing, treatment and retention needs of mothers living with HIV and their infants and young children.

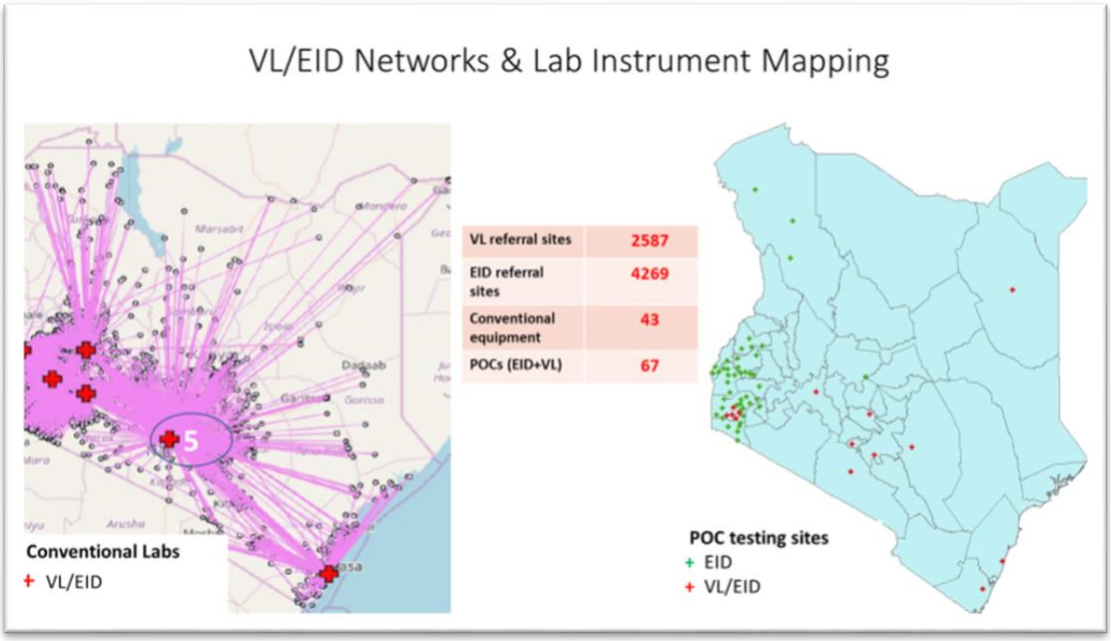
Although Kenya's PMTCT program has made immense strides over the years through very high coverage of PMTCT services for pregnant and breastfeeding women and their infants who access antenatal care, the national mother-to-child HIV transmission (MTCT) rate is 11%. Some counties continue to achieve less than 80% of two-month EID coverage (FY20 Q1 overall proxy 2m EID coverage was 72% and proxy 12m EID coverage was 93%). In the

PEPFAR-Kenya program, proxy linkage to ART is 88% on a national scale with variability between counties (75%-100% in FY20 Q1).
Following a UNITAID-funded project in 2017 that was implemented by CHAI and EGPAF, 67 instruments providing EID tests POC services were placed in Kenya: Alere Q (39); GeneXpert (28). The POC instruments were supported through UNITAID until the end of 2019.

A lab instrument mapping exercise demonstrated that the 67 POC instruments were placed in higher HIV burden counties in Western Kenya (Figure 1). These counties are also equipped with established sample referral networks, including four conventional laboratories. Site selection was determined by UNITAID's study requirements, which included location priority by selecting Homabay and surrounding areas where EGPAF was supporting sites. The site selection did not involve a laboratory optimization or mapping process with PEPFAR-Kenya. As of July 2020, only 17 of the 67 instruments have been utilized in 2020.

Although a clear transition plan was not part of the aforementioned study, PEPFAR/Kenya continues to provide technical assistance (TA) in testing and quality assurance for EID POC testing in COP19 and will do so in COP20. PEPFAR-supported TA includes EQA (provision of PT panels), direct and indirect facilitation of networking, and reviewing site-level results at PEPFAR-supported facilities. The conclusion of the time-limited EID POC support from UNITAID has resulted in ongoing conversations with national and county leadership and other stakeholders to determine the feasibility of supporting the existing POC instruments, taking into consideration the need for POC testing in addition to the existing successful and sustainable conventional EID testing platforms.

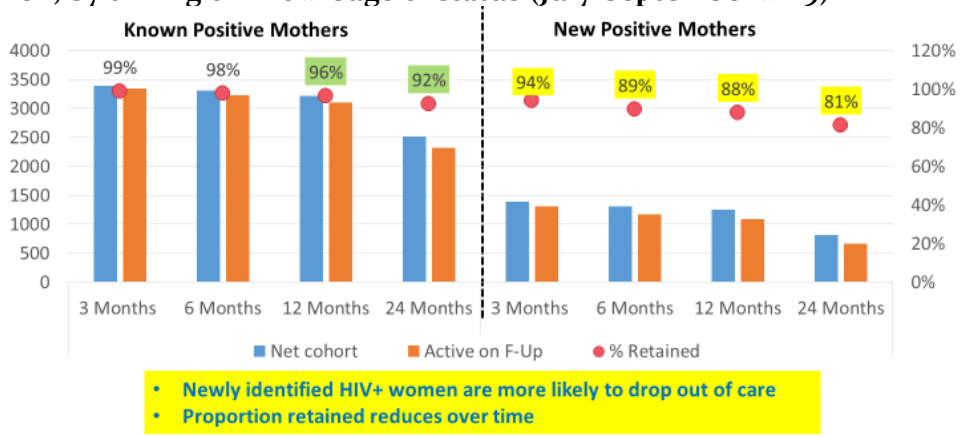
**Figure 1: VL/EID Lab Instrument Mapping**



**Programmatic Gaps**

As noted above, the key challenge for the PEPFAR/Kenya PMTCT program is to improve retention among mother-baby pairs and prevent vertical transmission of HIV. Retention is high among mothers with a known HIV-positive diagnosis prior to pregnancy and is much lower for women who are newly diagnosed as HIV positive during pregnancy at 3-, 6-, 12- and 24 months after time of diagnosis in ANC (see Figure 2) across the spectrum. To the greatest extent possible, community PMTCT programs should be supported by counties.

**Figure 2: PMTCT program gaps: Retention in care among pregnant and breastfeeding women, by timing of knowledge of status (July-September 2019)**




Source: PEPFAR Program Data, Western Kenya Partners (UCSF, CHS Shinda, Siaya MOH-Ngima, ICAP, EGPAF Timiza, UMB Timiza & KCCB-KARP)

| | | |
|---|---|---|
| Kisumu | 413 | 10.10% |
| Nairobi | 381 | 9.30% |
| Homabay | 378 | 9.20% |
| Siaya | 318 | 7.80% |
| Migori | 314 | 7.70% |
| Kakamega | 191 | 4.70% |
| Nakuru | 187 | 4.60% |

The PEPFAR-Kenya team has conducted an in-depth programmatic review to identify countries with high burden of new infant HIV infections and outstanding gaps precluding the elimination of MTCT. Seven counties account for 53% of infants identified as HIV-positive through PCR testing (PCR Audit 2016-2018, n=4092). Furthermore, a detailed root cause analysis demonstrated the majority of mothers of infants living with HIV are newly diagnosed HIV-positive during pregnancy or breastfeeding, did not attend ANC, and/ or started ART in the postnatal period. The majority of infants diagnosed with HIV did not receive infant ARV prophylaxis and were brought to clinics for HIV testing after 8 weeks of age (66%).

The data in the table below shows the difference in the infant outcomes between the infants who had their test done by conventional testing method or POC [126PCR positive infants (POC – 56, conventional –70] in Homabay (2019). Both methods have similarly high proportions reported as LTFU (16% for conventional testing compared to 14% with POC testing). Although EID POC instruments will not eliminate the key retention challenges driving Kenya's high MTCT rates, they can be incorporated into a comprehensive PMTCT program.

**Table 1. Outcomes of infants who received conventional EID testing compared to those who received EID POC testing.**

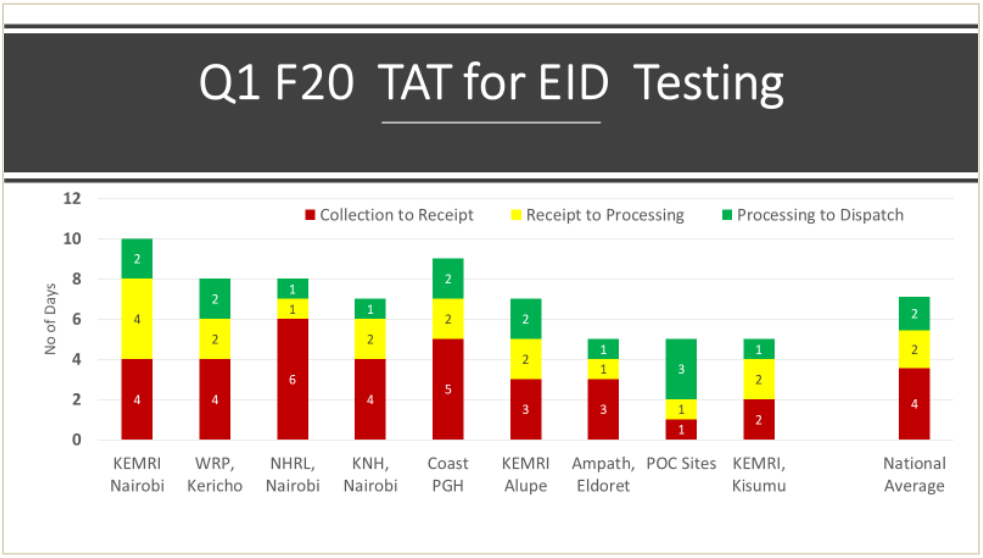
| **Infant outcomes** | **Conventional testing method** | | **POC instrument** | |
|---|---|---|---|---|
| Active | 38 | 54% | 32 | 57% |
| Transfer out | 14 | 20% | 10 | 18% |
| LTFU | 11 | 16% | 8 | 14% |
| Dead | 6 | 9% | 5 | 9% |
| Missing data | 1 | 1% | 1 | 2% |
| **Total** | **70** | **100%** | **56** | **100%** |

As evidenced by a median age of three months for infant HIV diagnosis of the HIV-infected infants (PCR audit 2016-2018 data), the primary challenge is retention of mother-infant pairs in HIV treatment and EID services and routine well care. Many (97%, KDHS 2014) infants do come for their first DPT 1 immunization at 6 weeks, and suboptimal HIV screening at this point contributes to missed opportunities for offering EID. PMTCT retention strategies require a client-centered approach, including cohort monitoring, case-based management, use of mHealth technologies, and peer mentorship. These interventions help provide individualized counselling, psychosocial support and health education, and they underscore the importance of maintaining routine follow-up for the mother's and infant's health (e.g., provision of infant prophylaxis, EID services, immunization services, family planning services, nutritional counseling, etc.).

**Analysis of Testing Platforms**

Infant EID samples are currently processed at a conventional lab, a POC hub ("near POC" testing), or immediately processed at the facility where the infant was tested. In COP20, Kenya will have 8 conventional labs that serve 4,270 facilities and 67 POC instruments that serve 490 facilities. Turnaround time (TAT) time is defined as the duration of time from phlebotomy services (sample collection) to when the results are available; intermediate steps include sample transport and sample processing. According to PEPFAR-Kenya's detailed analyses, the average TAT is eight days for conventional testing, five days for near POC testing, and less than day for POC testing (Figure 3).

**Figure 3. Q1 FY20 TAT for EID Testing**




Some of the current challenges being experienced include lack of commodities (including shortage of testing cartridges, reagents, and sample collection apparatus), unreliable power as some areas experience routine power outages, limited or lack of qualified human resources for health (HRH), and level of effort required from staff already experiencing heavy workloads at understaffed facilities. Also, because some facilities are already near other conventional platforms and have a short TAT, there is a preference to use their existing functional system over POC. These considerations increase the total amount of funding required to successfully support a limited number of EID POC instruments.

**Table 2: Overview of estimated costs associated with EID POC instruments placed in Kenya**

| | **Input** | **Estimated Cost** |
|---|---|---|
| **Fixed Costs:** | | **Total: $26,600590** |
| | Power back-up/UPS | $9,100090 |
| | Costs associated with ongoing operation and maintenance | $17,500 |
| **Recurrent Costs:** | | **Total: $16,000** |
| | HRH | $15,000/year per instrument |
| | Internet Connectivity and Data Bundles | >$1000/year |
| **Test cartridges and transport** | | **Total: $15.4/test** |
| | Cartridges | $14.9/test |
| | Sample transport | $2/batch of five samples. |
| **Anticipated total costs** | | |
| | Per machine/per annum | **$50,000** |

Although the program experiences a relatively short conventional lab TAT (average TAT of eight days), the program is committed to continuous improvement. The conventional testing system is being strengthened through identifying sample network efficiencies, implementing daily sample transport and adopting newer, more efficient testing platforms with higher throughput capabilities and the capacity to reduce average TAT to three days

(less than the current average TAT for near POC testing). Additionally, investments have been made on electronic data systems which allow easy access of results, expediting the return of results to caregivers and potentially decreasing the time to infant ART initiation.

**Table 3: Comparing EID PoC Capacity in 2018 to 2019**

| EID - POC Capacity | 2018 | 2019 | 2020 |
|---|---|---|---|
| # of PoC instruments available for EID | 52 | 67 | 17 as of July 2020*- |
| EID POC testing capacity | 104,160 | 134,201 | 34,030 (based on 17 instruments) |
| # of EID tests performed | 15,885 | 23,551 | 3663 |
| EID capacity utilization | 15% | 17% | 22% (as of mid-year) |
| Overall % of EID samples processed on PoC instruments | 11% (15,885/136674) | 14% (23,551/157,944) | 4.8 % (3663/75144) |
| Number of referring sites | 515 | 490 | 75 |

**Currently POC instruments are located both in high volume and low volume facilities that serve as hubs for optimal lab networks*

**Considerations for POC instrument placement**

The primary benefit of EID POC instruments is the potential to provide same day ART initiation to infants identified as being HIV-positive. POC instruments can be particularly useful in areas that do not have strong, reliable conventional lab systems or sample transport systems. The currently allocated EID POC instruments have limited daily capacity (daily maximum: 16 tests/instrument), which precludes substantial contribution to high volume facilities with conventional testing capabilities or significant contribution to many networked sites.

Most of the associated costs are , commodities, routine maintenance, quality assurance, and HRH needs. The cost of conventional testing is $9.6 per test compared to POC which is currently at $15.4. Although PoC instruments will not eliminate MTCT in Kenya, an evidence-based deployment of select instruments may help illuminate best PMTCT practices. PEPFAR/Kenya has identified existing, unutilized EID POC instruments that can be reallocated to sites within the same county to maximum client access benefits and return on investments.

**Data-Driven Site-Selection:**

EID POC **instruments** can be useful in sites where infants are identified as being HIV-positive but not promptly linked to ART due to longer than average TAT with conventional EID testing and/or caregivers unable to return for results and infant ART initiation. PEPFAR will support the 6 POC machines in the selected sites:

1. Lodwar County referral Hospital-Turkana County (USAID)

2. Kakuma Mission Hospital- Turkana County (USAID)
3. Muhoroni SCH- Kisumu County (CDC)
4. Mbita Sub county Hospital- Homabay county (CDC)
5. Bondo Sub county hospital-Siaya County (CDC)
6. Mtongwe Military Outreach Clinic (MMOC) -Military site in Mombasa County(DOD)

In a review of infant ART linkage rates from FY19 Q2-FY20 Q1, counties with the lowest treatment linkage among more than one infant living with HIV are Nakuru, Machakos, Kiambu, Migori, Kakamega, Nairobi, and Mombasa (Table 3). It is important to note that most infants diagnosed with HIV yet not reported to be linked to treatment are those admitted at referral hospitals who are discharged prior to the availability of the EID results. In these settings, POC machines may facilitate linkage to ART, although retention of mother-infant pairs will require ongoing support.

**Table 4: Top counties with high volume and low infant linkage to ART for FY19 Q2 – FY20 Q1**

| County Level HEI Data for FY19 Q2 – FY20 Q1 | | | | |
|---|---|---|---|---|
| **County** | **HEI Linkage <=2 Months** | **PMTCT_HEI_POS_ART <=2 Months** | **PMTCT_HEI_POS <=2 Months** | **PMTCT_EID_2 mo coverage** |
| Nakuru County | 67% | 10 | 15 | 70% |
| Machakos County | 71% | 5 | 7 | 74% |
| Kajiado County | 78% | 7 | 9 | 60% |
| Kirinyaga County | 78% | 7 | 9 | 102% |
| Narok County | 78% | 7 | 9 | 71% |
| Kiambu County | 79% | 23 | 29 | 73% |
| Nandi County | 83% | 5 | 6 | 82% |
| Migori County | 86% | 30 | 35 | 79% |
| Taita Taveta County | 86% | 6 | 7 | 81% |
| Kakamega County | 88% | 28 | 32 | 63% |
| Nairobi County | 88% | 52 | 59 | 75% |
| *Mombasa County* | *89%* | *16* | *18* | *80%* |

**Pink signifies lower coverage with higher volume of HIV+ infants, blue second tier*

The three counties highlighted in green above have low EID coverage, prompting additional site-level analysis resulting in the identification of six sites that may benefit from the placement of a PoC instrument. However, taking a comprehensive look at additional factors that impact low coverage, such as cultural practices that ban women from leaving home early postpartum (i.e., in Narok and Kajiado counties). Narok and Nakuru counties did not benefit in the previous POC EID distribution and thus due to current POC-EID MOUs with the counties, it's unlikely to institute inter county negotiations. In view of this challenge, choice of facilities was based on counties with existing POCs but prioritized to

facilities with the greatest EID gap/need. We recommend placing the PoC instruments in Lodwar County referral hospital- Turkana, Kakuma mission Hospital-Turkana**,** Bondo **Sub-County hospital** in Siaya county and Mtongwe Military Outreach Clinic in Mombasa county.

**Below is a justification for each selected site:**

**Bondo Sub-County Hospital:** In the 6 sub counties of Siaya County, Bondo contributes the highest PCR positives and new PMTCT Pos numbers. The facility is strategically located to support CHS (lead IP) who are a recipient of ambition funding in COP 20 to improve PMTCT ART retention, EID coverage < 2 months, infant HIV case detection and linkage to ART. The county has 3 POC machines (not in use) that can be relocated and supported.

**Lodwar County Referral and Kakuma Mission Hospitals:** Turkana county is geographically vast, rough terrain and with a population that is traditionally nomadic making sample transportation a challenge. USAID has selected Kakuma Mission Hospital (Turkana West sub County) and Lodwar County Referral Hospital (Turkana Central Sub County) based on the distances apart and the fact that they have existing POC machines. Kakuma Mission Hospital will be the hub site for Aposta Dispensary, IRC Kakuma Hospital, Kakuma Health Centre, Lokichogio (AIC), Health Centre, Lopiding Sub-District Hospital, Oropoi Dispensary. The following sites will be spoke sites for Lodwar County Referral Hospital:- Kalokol (AIC) Health Centre, Kerio Health Centre, Namukuse Dispensary, St Catherine's Napetet Dispensary, St Mary's Kalokol Primary Health Care Programme, St Monica's Nakwamekwi Dispensary, and St Patrick's Kanamkemer Dispensary. Collectively, the sites listed above contribute to 69% of the EID targets in Turkana County. The existing partner has motor bike riders with cooler boxes, further enhancing sample transportation.

**Mbita Sub-County Hospital:** Located in Homabay county, Mbita sub county has six islands in Lake Victoria and hard to reach mainland topography with sites which are far apart and there are delays in the sample transport that rely on good weather for the samples to be shipped by boat to the mainland laboratories. There is an existing UNITAID POC machine at the hospital that proved useful at the pilot phase but stopped operations due to lack of sustained cartridge supplies. There will be no relocation requirements.

**Mtongwe Military Outreach Clinic (MMOC)** is a government level three (Health Centre) facility in Likoni Sub-county of Mombasa County. It is located in the South Coast region in the neighborhood of Kenya Navy barracks and provides outpatient and HIV/TB treatment services including lab services to over 10,000 civilians living in informal settlements around the military base as well as military personnel. The facility has a GeneXpert machine supporting TB services that is well networked with neighboring facilities including faith-based facilities, Kenya Navy and Kenya Army medical facilities. Recently, the facility was upgraded to serve as the Mombasa County outreach hospital with a focus on enhancing mother-baby pair services and coverage. With the expanded scope and geographical

coverage, inclusion of EID services is possible with assured EID cartridge support. Currently all EID samples from this facility are sent to the Coast Provincial General Hospital across the ferry thus adding EID services in the existing gene Xpert for TB will contribute towards timely access and improved PMTCT/EID outcomes in Likoni Sub-county of Mombasa County.

**Muhoroni Sub-County Hospital**: Located in Kisumu County, a high HIV burden area and this facility serves a large catchment area with many residents unable to access the facility due to the poor or non-existent road network. This area has a huge sugar plantation and the facilities are far from each other. Nineteen (19) low volume facilities in the catchment area can be linked to optimize instrument capacity. The current EID POC instrument is placed in JOOTRH and team propose that ICAP, UCSF and county government of Kisumu be engaged in the machine relocation.

**Table 5. FY20 SAPR PMTCT Results for the Six Selected Sites**

| SAPR 2020 Results | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Facility Name | PMTCT_HEI_POS 2 - 12 months | PMTCT_HEI_POS <= 2 months, | Total pos infants | PMTCT_HEI_POS 2 - 12 months , Receiving ART | PMTCT_HEI_POS <= 2 months, Receiving ART | Total HEI POS on ART | PMTCT_EID Testing 2 - 12 months | PMTCT_EID Testing <= 2 months | PMTCT ANC pos Q1 | PMTCT ANC pos Q2 | Post ANC pos | Total POS (ANC and post ANC) | EID testing < 2months | ART linkage |
| Mbita Sub-County Hospital | 0 | 0 | 0 | 0 | 0 | 0 | 7 | 62 | 26 | 53 | 1 | 80 | 78% | #DIV/0! |
| Muhoroni County Hospital | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 13 | 22 | 16 | 0 | 38 | 34% | #DIV/0! |
| Bondo District Hospital | 1 | 0 | 1 | 1 | 0 | 1 | 93 | 3 | 1 | 2 | 11 | 13 | 23% | 100% |
| Mtongwe Military Outreach Clinic | 0 | 0 | 0 | 0 | 0 | 0 | 31 | 26 | 12 | 17 | 0 | 29 | 90% | #DIV/0! |
| Lodwar District Hospital | 2 | 1 | 3 | 2 | 1 | 3 | 11 | 41 | | | | | #DIV/0! | 100% |
| Kakuma Mission Hospital | 1 | 1 | 2 | 1 | 1 | 2 | 25 | 12 | | | | | #DIV/0! | 100% |

**Selection and support of supported POC sites:**

The PEPFAR/Kenya program remains committed to the well-being of mothers and infants affected by HIV and swiftly achieving EMTCT in Kenya. PEPFAR's POC support will span 6 sites (3-CDC, 2 USAID and 1 to DOD), and 82 networked sites as indicated above at an average cost of $50,000 per annum. PEPFAR/Kenya currently anticipates directly supporting six EID PoC instruments through September 2023 and will support assessing the impact of this investment. To maximize on the POC placements, these networked peripheral sites ranging from 3 to 25 to a hub are mostly low-volume/lower-level with few EID samples per month. PEPFAR will commit to procuring the commodities for these machines through the implementing partner that will support the placement. The same implementing partner will support the HRH, sample transport, internet and power-back up (UPS). This support for POC EID machines complements the ongoing support that PEPFAR-Kenya provides for a comprehensive COP20 PMTCT program to help propel Kenya towards eliminating mother-to-child transmission of HIV.